pbrc
Permian Basin
Rehab Center

620 N. Alleghaney
Odessa, TX 79761
phone 432.332.8244
metro 432.580.4304
fax 432.580.7428
website www.pbrehab.com

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. IF YOU HAVE ANY QUESTIONS PLEASE FEEL FREE TO ASK FOR ASSISTANCE.

PEDIATRIC Patient Information Form

Child's Full Name		Previous Patient? Yes ☐ No ☐		**Today's Date**	
Street Address					
City		State		Zip Code	
Date of Birth		Age		Gender	Male or Female
Child's Social Security #		Child's Physician			
Home Phone Number	( )	Cell Phone Number	( )		

Parent/Guardian and Transportation Information

Parent/Guardian(s) Full Name		Relationship to Patient	
Place of Employment		Work Phone Number	
Insurance Information		ID#	DOB of Policy Holder

Emergency Contact

Name:		Relation:		Phone Number:	

Other Information – Please Circle

What languages are spoken in the home?	English - Spanish - Sign Language - Other:
What languages does the patient speak?	English - Spanish - Sign Language - Other:
What language does the patient speak most of the time?	English - Spanish - Sign Language - Other:
What language does the caregiver/family speak most of the time?	English - Spanish - Sign Language - Other:
Race/Ethnicity of the Patient	African American - Amer. Indian - Asian - Caucasian - Hispanic - Other
How did you hear about our facility?	Doctor - Family/Friends - School - Phone Book - Other:

Medical History

1. List current medications taken by patient:
2. List all current allergies:
3. List previous surgeries:
4. List any medical condition or diagnosis we should be aware of:

General Information

Is the child receiving any home health, ECI, or school services?		YES	NO
If yes, what kind of services? ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy			
If school age, what school does the patient attend?		Grade	
Are there any academic concerns?		YES	NO
What is the reason for therapy?			
What are your goals for the patient?			
Does the patient have difficulty eating or swallowing?			
Does the patient own or need medical equipment?			
Are there any safety precautions, questions, or concerns?			

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Patient's Name		DOB	

Attendance Policy

I have been given the Permian Basin Rehabilitation Center Attendance Policy. I understand and agree to the conditions.

Initials

Authorization for Therapy Services

I give permission for the name listed above to be treated by PBRC for the purpose of an evaluation and/or therapy in one or all of the following: Audiology, Speech, Physical, Occupational therapy and/or other. I understand and agree to the therapy sessions which may take place in open or public areas. I also understand that therapy may be received in a treatment room with a shared observation booth.

Initials

Assignment, Release and Payment Policy Agreement

I understand that I am financially responsible for all charges incurred. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I understand payment for services rendered will be due upon receipt of services unless payment arrangements have been made prior to onset of services. Failure to pay within 15 business days will result in suspension of therapy services immediately as per policy.

Initials

Authorization to Release Medical Information to Individuals or Family Members

In accordance with Federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in order for the PBRC or staff to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode, or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

____ **I do NOT authorize** PBRC to release any or all information concerning my medical care.
____ **I do authorize** PBRC to release any or all information to the following below:

Name: _____ *Relationship to Patient:* _____

Name: _____ *Relationship to Patient:* _____

Initials

Authorization to Obtain or Release Medical Records from Medical Providers

I hereby authorize the PBRC to obtain any necessary medical records from any physician, hospital, or other health care professional that has provided medical care to me in the past. I also authorize the PBRC to release any medical records concerning my care to any physician, hospital, or other health care professional providing care to me at any time. Additionally, I authorize the PBRC to release pertinent medical records concerning my care to Medicare, Medicaid, insurance company, third party administrator, or any managed care company.

Acknowledgement of Receipt of Privacy Practices

I have received a copy of the Permian Basin Rehabilitation Center's Notice of Privacy Practices effective September 23, 2013. I understand my rights to privacy and the circumstances under which my health information may be released.

Initials

In signing below, the patient/authorized signature, acknowledge they have read, understand and agree to the above notices.

Print Authorized Name: _____ Relationship to Patient: _____

Authorized Signature: _____

PBRC Staff: _____ Date: _____

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SOCIAL SERVICE FORM

SOCIAL WORK SERVICES ARE AVAILABLE TO ALL PATIENTS AND THEIR FAMILIES AT PBRC. SOCIAL WORKERS CAN HELP CONNECT PEOPLE WITH SERVICES THAT ARE AVAILABLE TO THEM IN THE COMMUNITY. PLEASE FEEL FREE TO CONTACT THE SOCIAL WORKER AT ANY TIME WITH ANY QUESTIONS, CONCERNS OR NEEDS.

IS YOUR FAMILY NEEDING ASSISTANCE WITH ANY OF THE FOLLOWING?

Meals_____ Transportation_____ Utilities_____ Clothing_____ Other_____
Family Problems_____ Anxiety_____ Anger_____ Depression_____
Sadness_____ Other_____

ARE YOU CURRENTLY RECEIVING SERVICES FROM ANY AGENCIES?

Disability_____ Food Stamps_____ Respite Care_____
Department of Assistive & Rehabilitative Services (DARS)_____
Temporary Assistance for Needy Families (TANF)_____ Women, Infants & Children (WIC)_____
Supplemental Security Income (SSI)_____ Other_____

TRANSPORTATION:

How do you plan to get to your appointments?
Drive myself_____ Friend_____ Public Transportation/Taxi_____ Spouse/Family_____
Other: _____

ANY OTHER COMMENTS OR QUESTIONS:

_____

_____

_____

_____

I WOULD LIKE TO BE CONTACTED BY THE SOCIAL WORKER: YES_____ NO_____

_____ _____
Client's Printed Name **Client's Signature (Parent or Guardian if minor)**

_____ _____
Social Worker **Date**

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Attendance Policy

Permian Basin Rehab Center strives to provide consistent, high quality therapy services for each patient. In order to obtain the maximum benefit from skilled therapy services, it is important that patients attend scheduled appointments on a consistent basis. Poor attendance affects therapy outcomes.

- Please be sure to arrive to the scheduled appointment time at least **15 minutes early**
- Patients must provide the facility with working phone numbers and/or email addresses so that we can communicate important information.
- It is required that a patient attend 75% of their scheduled appointments. Failure to do so may result in schedule changes or dismissal. Three or more unexcused absences or two or more weeks of excused absences in a month may result in dismissal from services. A doctor's referral and a new evaluation will be required to resume services. Your insurance company may require a 6 month waiting period. It is important to communicate with your therapist regarding illnesses, schedule conflicts, or emergencies.
- Treatment sessions should be cancelled if the patient is contagious or has had a fever in the past 24 hours. Please make every effort to notify the center of your absence prior to your scheduled appointment.
- Patients should arrive on time and be prepared to participate in therapy. To ensure success bring any necessary equipment to therapy (i.e., wheelchair, glasses, braces, hearing aids, communication device, etc.). **Arriving more than 15 minutes late could result in a cancelled session.**

Each appointment time is valuable and set aside for patient care. Out of respect for your time and family, we work very hard to see each patient at their appointment time and stay on schedule. We realize that there are times that our therapists may have to cancel your appointment due to training, illness or vacation. If the therapist cancels your appointment, every effort will be made to reschedule when possible to ensure consistency of care.

Thank you for allowing us to provide therapy services to you and your family.

_____ _____

Patient/Authorized Signature Date

_____ _____

Therapist/Staff Signature Date

All complaints or concerns can be directed to:
Kim Ortega, M.C., CCC-SLP, Clinic Director
Wade Kuehler, Executive Director

Revised 6/17/2015

PERMIAN BASIN REHABILITATION CENTER
620 North Alleghaney; Odessa, Texas 79761
Main #432-332-8244; Fax #432-580-7428

KEEP THIS FOR YOUR RECORDS

Notice of Privacy Practices

Effective Date: 04/01/2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include any or all of the following: physical therapy, speech therapy, occupational therapy and audiological services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your Medicare or Medicaid plan or insurance for therapy or audiological services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
Permian Basin Rehabilitation Center
c/o: Kathy Hollmann Clinical Co-ordinator
620 North Alleghaney
Odessa, Texas 79761
(432) 332-8244

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)