Bay Area Rehabilitation Center *Where Disabilities Become Possibilities*

5313 Decker Dr. Baytown, TX 77520 (281) 838-4477 FAX (281) 838-4481

Pediatric Program Attendance Policy

1. Importance of consistent attendance

It is important to attend your scheduled appointments. Poor attendance will reduce the effectiveness of therapy and impact your child's outcomes or goal achievement. Your child's frequency of therapy is directed by your physician's orders. When you are out of compliance, we will notify your physician. For Bay Area to continue to provide quality services, our therapists must be given the opportunity to work in as efficient and effective an environment as possible. Failure to provide advance notice, generally considered during business hours the day prior for early morning appointments and no less than two hours for appointments in the afternoon, of your absence prevents the staff from using that time to assist another client.

2. Attendance Policy and Actions Taken

- **Clients must attend 75% of their scheduled appointments in a 30 day period.** If a client does not meet this criteria, he/she will be removed from the therapist schedule and discharged from therapy. We will attempt to notify you by phone. This policy will be strictly enforced.
- **Please be early or on time.** You are scheduled for a set amount of time based on your physician's request. Typically we do not have the ability to go beyond your scheduled time so you will likely lose valuable therapy time when you are late.
- **Inactive clients will be discharged.** Based on your schedule, consecutive absences may result in your discharge from the program. A notice will be sent to you and your physician. You must return to your physician and obtain a new prescription prior to receiving a new evaluation.
- **If you have a change in medical status or hospital admission your status will be changed to inactive or you will be discharged.** For your own protection, you will need to be released from your physician and re-evaluated before returning to the active schedule.
- **Any discharge based on poor attendance will be reviewed before any future evaluations.**

3. Appreciation

We appreciate your business and will make every effort to accommodate a time that is mutually convenient. Exceptions to the policy will be considered on a case-by-case basis. If you feel that you have a situation requiring special consideration please contact the Pediatric Program Intake Coordinator.

4. Signature & Agreement

I have read and understand the Attendance Policy and agree to comply.

Client Name: _____ Client #: _____

_____ _____

Signature of Client/Caregiver **Date**

5313 Decker Drive, Baytown, TX 77520 (281) 838-4477 FAX (281) 838-4481

Conditions of Admission and Authorization for Treatment

1. Consent for Purposes of Evaluation, Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by the Center for the purpose of evaluating or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Center. My "protected health information" means health information, including my demographic information, collected form me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This protected health information related to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

The professional staff at the Center will complete a comprehensive evaluation according to the physician's prescription and/or diagnosis. The results of the evaluation will be discussed with me (and other appropriate family members) by the evaluating team. A treatment plan will be developed as a result of the findings of the evaluation. The evaluation and treatment plan will be submitted to the referring physician. Licensed personnel that are the most appropriate will provide the treatment to provide the services indicated.

✱I understand that evaluation or treatment of me by the Center may be conditioned upon my consent as evidenced by my signature on this document.

Please Initial: _____

2. Restriction on Protected Health Information

I understand I have the right to request a restriction at to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the facility. The Center is not required to agree to the restrictions that I may request. However, if the Center agrees to a restriction that I request, the restriction is binding on the Center.

If applicable: I have no restriction on the use and disclosure of my private health information. Please Initial:_____

3. Restriction of Confidential Communication

I understand I have the right to request a restriction as to how my protected health information is communicated to me. The Center will accommodate your reasonable requests to receive communications of medical information by alternative means or at alternative locations only if you specify the alternative location, address, or telephone number and/or the alternative means of contact.

If applicable: I have no restrictions on confidential communications.

Please Initial:_____

8. Releases

I have the authority to sign on behalf of the client, I have read the applicable releases and understand all of their terms. In consideration of permission granted me by the Center to participate in the activities of the Center, my initial indicate agreement with the terms and condition involved and agreement to participate. I execute these releases voluntarily, with full knowledge of the significance, and recognize my right to revoke them at any time by notifying the Center in writing, of my intent to do so.

Please Initial: _____

Authorization is hereby granted to the Center, in case of emergency, to transport, or have this client transported, to the hospital chosen by the agency and to obtain such treatment, as the attending physician deems necessary. The judgment of the staff of the Center shall be conclusive as to what constitutes an emergency. I hereby agree to be financially responsible for all charges thus incurred.

Please Initial: Agree _____ Disagree _____

If it is necessary for this client to take medication while in the care of the Center, I hereby grant permission for this to be done with the assistance of the staff of the Center, as needed. I understand that medications must be in the original container with specific directions for administering and the prescribing physicians name.

Please Initial: Agree _____ Disagree _____

The Center is a charity funded in part by the United Way and donors. This involves tours, photos, and publications about the Center. I hereby grant permission to release any and all photographs taken with relation to the participation of the client at the Center and to use said photographs and related information in news stories, brochures, informative literature, etc. promoting or publicizing the Center.

Please Initial: Agree _____ Disagree _____

I hereby release and discharge the Center, its agents, employees, and officers from all claims, demands, actions, judgments, and execution, which I and/or the client ever had or now have or my have or claim to have against the Center, its successors, and assigns, for all personal injuries known or unknown and injuries to property, real or personal, caused or arising out of the activities of the Center.

Please Initial: Agree _____ Disagree _____

I hereby certify and state that I have read, and that I fully and completely understand this Conditions of Admission and Authorization for Treatment, and I have signed the Conditions of Admission and Authorization for Medical Treatment, knowingly, freely, and voluntarily. I acknowledge by signing I give permission for the staff of the Center, its contract service providers, and others as described in the plan of care to provide treatment to me or my family member. I understand that I have the right to revoke the consent for purposes of evaluation, treatment, payment and health care operations, in writing, at any time, except to the extent that the Center has taken action in reliance on this consent.

Client/Parent/Guardian Signature	Signature of Admission Staff
X **Date: ___/___/___**	**X** **Date: ___/___/___**

Client: _____ Client #: _____

Bay Area Rehabilitation Center ***Where Disabilities Become Possibilities***

5313 Decker Drive, Baytown, TX 77520 (281) 838-4477 * Fax (281) 838-4481

Social Service Survey

Date:_____ Name:_____

Preferred Language: ☐English ☐Spanish ☐Other _____

Occupation:☐ Student ☐Part Time ☐ Full Time ☐Retired ☐Off work temporarily ☐Other

	1. Do you need the Social Worker to help with these items?		2. If yes - is the need immediate?		3. If yes - will the need affect your treatment goals	
Vision	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes
Hearing	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes
Dental	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes
Self Care	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes
Emotional Help	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes
Behavioral Help	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes
Financial Assistance	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes
Employment Assistance	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes
Abuse/Neglect/Exploitation	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes
Support System	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes
Housing	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes

Bay Area Rehabilitation Center ***Where Disabilities Become Possibilities***

5313 Decker Drive, Baytown, TX 77520 (281) 838-4477 FAX (281) 838-4481

Client: _____ Client #: _____

Medication List

Name of Prescription Medication	Prescribing Physician	Telephone Number of Prescribing Physician

Over the Counter Medications

_____ _____

_____ _____

_____ _____

_____ _____

Please complete this information and bring it with you at your next visit.
Thank you.