EXCEL Rehab Services
10031 Pines Blvd. Suite 217, Pembroke Pines, FL 33024
Nivia@excelwellnessnrehab.com 305.389.1769

Consent and Release of Photographs / Videos

☐ I, _____ (client or parent/guardian name) give consent to [Private practitioners name or private practice name] or any party authorized by [Private practitioners name or private practice name] to photograph and/or video record _____ (client name) in connection with his/her therapy sessions, for any purpose subject to the therapist's discretion including but not limited to educational publication, for teaching purposes, and demonstration of progression of his/her skills.

☐ I authorize [Private practitioners name or private practice name] to use pictures of _____ (client name) for promotional purposes (ex. brochures, website, etc.)

☐☐I acknowledge that I will receive no financial compensation for providing consent since my participation with [Private practitioners name or private practice name] in providing my consent and release is voluntary.

☐ I hereby release [Private practitioners name or private practice name], their contractors, their employees and/or any third parties involved in the creation or publication of [Private practitioners name or private practice name]. Publication from any and all liability that may arise in connection with the expressed and implied use of all photographs and videos outlined in this form.

☐ I reserve the right to revoke this agreement at any time. I understand that my right to revoke must be done in writing.

I am the client, parent or legal guardian of the person named below and have the legal authority to execute this consent and release.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

Excel Rehab Services Inc.

Patients last name/Apedillo	Patients first name /Nombre

Address/Direccion			
City/Ciudad	State/Estado	Zip code/codigo postal	Gender □ male □ female

Telephone/telefono	Date of birth/Fecha de nacimiento	Social security #/numero de seguro social

Emergency Contact Information/ En Caso de Emergencia

Name/Nombre	Telephone number/ Numero de Telefono

PATEINT INSURACE INFORMATION	INFORMACION DE SEGURO
Medicare #	OTHER PRIVATE PRIMARY INSURANCE (Name and Policy numb)
Medicaid #	Other secondary insurance name and number

RECORDS RELEASE AND TREATMENT AUTHORIZATION

I authorize any holder of my personal medical or other records, necessary to this or any other related claim, to release such records to the social security administration, or its intermediaries or carriers. A copy of the "form" is permitted by me to be used in place of the original to request direct payment of medical benefits to Excel Rehab Services, Inc.. Further, I understand and agree that I am fully responsible for any charges that are not reimbursable by my insurance company.

Autorizo a cualquier persona en posesión de historias clinicas o cualquier otro documento clinico que pueda requerirse para finalizar una reclamacion de pago para este proveedor, que comparta dichos documentos con la administracion del Seguro Socialy sus agentes. Autorizo que una copia de esta planilla sirva de original para el proposito de lograr pagos de beneficios medicos a Excel Rehab Services Inc.. Reconozco y acuerdo que me hare responsible por el pago de cualquier cargo por servicios que no sean cubiertos por mi compañia de seguros.

I hereby authorize Excel Rehab Services Inc. to render appropriate services as prescribed by my physician, or any other physician who may be treating me, including all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgement of the physician. I hereby releas Excel Rehab Services e, Inc. from all liability incurred as a result of medical treatments provided by staff of the facility.

Autorizo Excel Rehab Services, Inc. a que me rindan aquellos servicios ordenados por mi medico, o por cualquier otro medico que me este tratando, incluyendo todas las pruebas diagnositicas y/o tratamientos terapeuticos que sean recomendables o necesarios, en la opinion del medico. Exonero a Excel Rehab Services, Inc. de toda responsabilidad que pueda incurrir como resultado del tratamiento clinico que se me otorge por parte de los empleados del mismo.

SIGNATURE OF PATIENT/FIRMA DEL PACIENTE	DATE/FECHA
SIGNATURE OF CAREGIVER/FIRMA DEL REPRESENTANTE DEL PACIENTE	DATE/FECHA

EXCEL REHAB SERVICES
REFERRAL FORM

Child's Name:_____

Date of Birth:_____ Age:_____ _____Sex:_____

Parent(s)/Guardian:_____

Mailing Address:_____

Home Phone:_____Work Phone:_____

Cellular Phone:_____ Email:_____

Primary Language:_____Other Languages:_____

Referral Source:_____ E-mail:_____

_____

Emergency Contact:_____Telephone#_____

Parent work place/guardians:_____Work#_____

Payee/Insurance:_____ ID#_____

Primary Care Physician:_____ Telephone#_____

Fax#_____ Type of Therapy:_____

Diagnosis:_____

Notes:_____

_____

Excel Rehab Services
10031 Pines Blvd. Suite.217
Pembroke Pines FL 33024
Ph.305.389.1769 Fax.954.441.4458

Were there any unusual conditions that may have affected the pregnancy or birth?

_____

Medical History

Does your child have a history with:

Ear infections	Yes	No
PE tubes	Yes	No
Frequent colds/sinus infections	Yes	No
Bronchitis/pneumonia	Yes	No
Drainage from ear	Yes	No
Tonsils/adenoids removed?	Yes	No

Has child experienced any of the following? Please explain all "yes" responses below:

Visual difficulties	Yes	No
High fevers lasting longer than 1 day	Yes	No
Seizures/Convulsions	Yes	No
Tuberculosis	Yes	No
Asthma	Yes	No
Hospitalization	Yes	No
Surgery	Yes	No
Head injury	Yes	No
Swallowing/chewing problems	Yes	No

Other:
Please explain all "yes" answers:

_____

_____

Does child have any medical diagnoses? (e.g., ADD, autism, dyslexia)?

_____

Is the child taking any medications? _____ If yes, identify:

_____

Does your child have any known allergies? If yes, identify:

_____

Developmental History

Did your child:

Hold his/her head up by 4 months?	Yes	No	What age?_____
First crawl by 12 months?	Yes	No	What age?_____
First walk alone by 16 months	Yes	No	What age?_____
Was toilet-trained by 3 years	Yes	No	What age?_____
First grasped crayon/pencil (thumb and finger) by 3 years?	Yes	No	What age?_____
First sit alone by 12 months?	Yes	No	What age?_____

First ate solid food by 12 months?	Yes	No	What age?_____
Fed self by 2 years?	Yes	No	What age?_____
First use scissors by 3 years?	Yes	No	What age?_____
Did child cry normally (to communicate pain, fear, discomfort, loneliness)?	Yes	No	What age?_____
Cooing/ babbling by age 4 months?	Yes	No	What age?_____
Respond to name/peek-a-boo by 8 months?	Yes	No	What age?_____
Using jargon* by 12 months?	Yes	No	What age?_____
Imitate sounds by 12 months?	Yes	No	What age?_____
Saying his first word by 15 months?	Yes	No	What age?_____
Saying 2 words together by 24 months?	Yes	No	What age?_____
using short sentences by 36 months?	Yes	No	What age?_____

• Jargon is defined as words that are not understandable, but are said in "sentences," where the child's inflections let you know that he is "saying something."

Has your child's hearing been tested previously? f yes, when and what were the results?

_____

Indicate with a checkmark any items that are difficult for your child:

Eating a variety of foods ____Understanding what he/she hears ____ Following directions or ...king in organized or grammatically correct sentences ____Answering questions ____Pl... ...orrectly ____Singing songs / reciting nursery rhymes ____Stating sounds of letters. ___... ... common" words Writing his/her name ____Rhyming Getting his/her point across, Thinking of words for things____ Understanding concept of time (seasons, day/night, hours) ____Telling stories Self-calming ____Receiving/giving hugs ____Keeping shoes on ____Eye-H...nd ___Coordination____ Using a straw ____Blowing bubbles ____Keeping hands to him/herself

Behavioral History

Please check all that describe your child:

____Friendly ____Impulsive/impatient ____ Separation difficulties ____Easy-going ____Difficulty sleeping ____Poor eye contact ____Plays well with other children ____Hyperactive ____Cooperative ____Aggressive/destructive ____Doesn't like to be read to ____Attentive ____Has temper tantrums ____Poor memory ____Willing to try new activities ____Unpredictable ____Sleeps well ____ Defiant ____Will not eat certain textures ____Eats well ____Cannot easily shift from one activity to another ____Will not touch certain textures ____Plays alone for reasonable amount of time ____Bites nails ____Overly sensitive emotionally ____Doesn't like to be touched ____ Stubborn ___Still uses pacifier/sucks thumb ____Talkative ____Bad-tempered ____ Has nightmares ____Clumsy ____Cries easily ____Grinds teeth, Distractible/short attention span ____Wets bed ____Easily frustrated ____ Withdrawn ____Mouth breather ____Restless____ Shy ____ Snores ____Quiet ____Daydream often ____Sensitive to sounds.

Educational History

School _____

Grade _____ Teacher(s) _____

How is the child doing academically (or pre-academically)?

_____

_____

Does the child receive special services? _____ If yes, describe

_____

How does the child interact with others: (e.g., shy, aggressive, uncooperative, etc.)

_____

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? _____ If yes, describe the most important goals:

_____

Provide any additional information that might be helpful in the evaluation or remediation of the child's problem:

_____

_____

Person completing form: _____ Date _____

Signature: _____ Relationship to child: _____

Excel RehabServices,INC
10031 Pines Blvd. Suite.217
Pembroke Pines,FL 33024

Authorization to Release Medical Information

I,_____ DO HEREBY AUTHORIZE TO EXCEL REHAB. TO OBTAIN AND RELEASE ANY MEDICAL OR OTHER PERTINENT INFORMATION ABOUT MY CHILD _____.
PARENT /GUARDIAN SIGNATURE:_____ DATE:_____

I AUTHORIZE THAT PAYMENT OF MEDICAL BENEFITS BE ASSIGNED TO BUILDING BLOCKS REHAB. I ASSIGN THE MEDICAL BENEFITS FOR THERAPY SERVICES TO EXCEL REHAB, THE PROVIDER OF THERAPY SERVICES. I UNDERSTAND THAT I AM RESPONSIBLE FOR A) ANY AMOUNT APPLIED TO THE DEDUCTIBLES BY THE INSURANCE CARRIER, AS WELL AS THE PERCENTAGE OF CO-INSURANCE AND ANY NON-COVERED SERVICES INCURRED UNDER ANY PRIVATE, HEALTH MAINTENANCE ORGANIZATION (HMO) EARLY INTERVENTION CENTER AND/OR MEDICAID PROGRAM, AND B)FOR CHARGES NOT PAID BY MY INSURANCE. EXCEL REHAB MAKES EVERY ATTEMPT TO ENSURE THAT AUTHORIZATION FOR SERVICES ARE RECEIVED PRIOR TO THE INITIATION OF SERVICES AND WILL NOTIFY YOU ONA TIMELY BASIS IF THAT STATUS CHANGES; HOWEVER PAYMENT FOR SERVICES RECEIVED IS ULTIMATELY THE PARENT/GUARDIAN'S RESPONSIBILITY.

PARENT/GUARDIAN SIGNATURE:_____ DATE:_____

EXCEL REHAB SERVICES CANCELLATION POLICY
EXCEL REHAB SERVICES REQUIRES A 24 HOUR CANCELLATION NOTICE. IT IS NOT OUR INTENTION TO PENALIZE ANYONE FOR LEGITIMATE EMERGENCIES OR ILLNESSES WHICH MAY NOT PERMIT YOU TO NOTIFY US 24 HOURS PRIOR TO YOUR APPOINMENT AND EACH INSTANCE WILL BE INDIVIDUALLY REVIEWED.

PARENT/GUARDIAN SIGNATURE:_____ DATE:_____

THERAPY APPOINTMENTS

THERAPY IS SCHEDULED AT A SPECIFIC TIME, IF YOU ARRIVE LATE FOR YOUR APPOINMENT, WE WILL ENDEAVOR TO GIVE THE PATIENT THE ALLOTTED TREATMENT TIME, HOWEVER, THE TREATMENT WILL CONTINUE FOR AS LONG AS OUR SCHEDULE WILL PERMIT.

PARENT/GUARDIAN SIGNATURE:_____ DATE:_____

EXCEL REHAB SERVICES
HOJA DE REFERIDO

Nombre del Paciente:_____

Fecha de Nacimiento:_____ Edad:_____ _____Sexo:_____

Nombre de los padres:_____

Direccion:_____

Telefono:_____TelefonoCelular:_____

IdiomaPrimario:_____OtrosIdiomas:_____

Referidopor:_____ CorreoElectronico:_____

_____

Encaso de emergencia ,contactar:_____Telefono#_____

Centro de trabajo de los padres:_____Telefono#_____

Pagador/Seguro:_____ ID#_____

Nombre del Doctor:_____ Telefono#_____

Fax#_____ Tipo de Terapia:_____

Diagnostico:_____

Notas:_____

_____

EXCEL Rehab SERVICES, INC
10031 Pines Blvd. Suite.217
Pembroke Pines FL 33024
Ph.305.389.1769 Fax.954.441.4458

EXCEL REHAB SERVICES

10031 PINES BLVD. SUITE 217

PEMBROKE PINES, FL 33024

CANCELLATION POLICY

Para asegurar de que nuestros terapeutas puedan planificar eficazmente su tiempo, y satisfacer las necesidades de los niños(as), se les pide a los padres comunicarse directamente con la terapeuta para cancelar la terapia con anticipación. La sesión podrá ser reprogramada si la terapeuta tiene la disponibilidad.

Excel Rehab cierra los días festivos mas importantes del ano. Pero las terapias pueden ser reprogramadas para que los niños(as) no pierdan las sesiones de los días feriados. Si usted planea salir de vacaciones, le pedimos el favor de avisarle a la terapeuta con tiempo para así planificar eficazmente le horario.

La asistencia a las terapias es muy importante para garantizar el desarrollo optimo del niño(a). Por esta razón, es importante tener en cuenta que si los padres cancelan mas de 50% de las sesiones del tratamiento durante 2 meses consecutivos se reducirá la frecuencia de la terapia. Entendemos que a veces suceden imprevistos, por esa razón es importante cancelar con anticipación. Si los padres durante 3 veces seguidas no cancelan la terapia con anticipación, el niño(a) perderá el turno en el horario.

Gracias por su cooperación

Firma del Padre/Guardian _____ Fecha _____

Excel Rehab Services

Historia Del Cliente

información General

Nombre: _____ Fecha Nacimiento: _____ Edad: _____ Sexo: _____

Dirección: _____ Teléfono: _____

¿Con quién vive el niño(a)? _____Idioma que hablan en la casa: _____

Nombre de la Madre: _____Nombre del padre: _____

Escuela/ Daycare: _____

Por favor describa porque está interesado en que realicemos la evaluación de habla y lenguaje a su hijo/a:

_____

_____

_____

Por favor describa la forma de comunicación que usa su hijo (gestos, palabras, frases cortas, oraciones)

_____

_____

_____

¿Cuándo fue el problema notado por primera vez?

_____

_____

¿Algún miembro de la familia presenta alguna dificultad en las siguientes áreas? (por favor encierre en un círculo, y si la respuesta es positiva por favor explique):

1. Problemas con la pronunciación de las palabras Si No
2. Problemas de Audición Si No
3. Problemas de Aprendizaje Si No
4. Convulsiones Si No
5. Autismo Si No

Información Medica:

Explique el estado de salud de la madre durante el embarazo (enfermedades, accidentes, medicamentos, etc)

_____

_____

Duración del embarazo: _____ ¿Hubo alguna dificultad durante el embarazo o durante el parto? _____ (si respondió si, por favor explique):

_____

_____

Tipo de parto: Vaginal____ Cesárea _____ Peso al Nacer: _____

Historia Medica del Nino(a):

¿Ha presentado su hijo(a) las siguientes dificultades?

1. Infecciones de Oídos recurrentes: _____
2. Tubos en los oídos (especificar si es uno solo oído o los dos) _____
3. Resfriados frecuentes: _____
4. Alergias: _____ Por favor especificar: _____
5. Dificultad al dormir (¿ronca en la noche?): _____
6. ¿Respira por la boca?: _____
7. ¿Problemas de visión?: _____ (si respondió "si" por favor explicar): _____
8. Fiebres altas: _____
9. Convulsiones: _____
10. Asma: _____
11. Dificultades durante la alimentación (dificultad para masticar o dificultar durante la deglución de las comidas), si respondió "si" por favor especificar: _____
12. ¿Tiene su hijo(a) algún diagnostico medico? (ADHD, Autismo, Dislexia, etc), Si respondió "si" por favor explicar cuando fue diagnosticado.
    _____
    _____
13. ¿Su hijo(a) es "picky eater?" Si respondió "si" por favor explique:
    _____
    _____
    _____
    _____
14. ¿Su hijo(a) recibe otras terapias diferentes a la terapia de lenguaje? (Si su respuesta es "si" por favor especificar cuales terapias y las frecuencias que recibe el niño(a) durante la semana)
    _____
    _____

Historia del desarrollo del Nino(a):

A que edad su hijo(a):

Balbuceo: _____

Dijo su primera palabra: _____

Uso mas de dos palabras para comunicarse: _____

Se sentó solo(a): _____

Gateo: _____

Se levanto solo(a): _____

Camino solo(a): _____

¿Su hijo(a) esta entrenado(a) para ir al baño? " _____

Nombre de la persona completando el formulario _____

Relación con el niño(a) _____

Fecha _____

EXCEL Rehab Services
10031 Pines Blvd. Suite 217, Pembroke Pines, FL 33024
Nivia@excelwellnessnrehab.com 305.389.1769

Consent and Release of Photographs / Videos

☐ I, _____ (client or parent/guardian name) give consent to [Private practitioners name or private practice name] or any party authorized by [Private practitioners name or private practice name] to photograph and/or video record _____ (client name) in connection with his/her therapy sessions, for any purpose subject to the therapist's discretion including but not limited to educational publication, for teaching purposes, and demonstration of progression of his/her skills.

☐ I authorize [Private practitioners name or private practice name] to use pictures of _____ (client name) for promotional purposes (ex. brochures, website, etc.)

☐☐I acknowledge that I will receive no financial compensation for providing consent since my participation with [Private practitioners name or private practice name] in providing my consent and release is voluntary.

☐ I hereby release [Private practitioners name or private practice name], their contractors, their employees and/or any third parties involved in the creation or publication of [Private practitioners name or private practice name]. Publication from any and all liability that may arise in connection with the expressed and implied use of all photographs and videos outlined in this form.

☐ I reserve the right to revoke this agreement at any time. I understand that my right to revoke must be done in writing.

I am the client, parent or legal guardian of the person named below and have the legal authority to execute this consent and release.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client