PPEC

CHILD ENROLLMENT FORM

Child's Name: _____ Enrollment's Date: _____

DOB: _____ Gender: _____ SSN: _____

Mother's Name: _____ Phone: _____

Address: _____

Father's Name: _____ Phone: _____

Address: _____

Legal Guardian's Name: _____ Phone: _____

Name & Ages of Siblings:

1. _____ 3. _____

2. _____ 4. _____

In order to ensure the safety of your child, we are requesting that you fill out the following authorization list. This list would include the people that you allow to pick up your child at the center or the people that we may leave your child with if they are dropped off by the bus.

✓-Anyone on the list should be prepared to show a photo ID.
✓-It is your responsibility to keep this list updated.
✓-Your child will not be left with someone who is not on the list without prior arrangement.

AUTHORIZATION LIST

Name: _____ Cell: _____ Other: _____

Name: _____ Cell: _____ Other: _____

Name: _____ Cell: _____ Other: _____

Name: _____ Cell: _____ Other: _____

Name: _____ Cell: _____ Other: _____

Name: _____ Cell: _____ Other: _____

Peek A Boo Pediatric Care PPEC

MEDICAL INFORMATION & HISTORY

Child's Name: _____

Pediatrician: _____ Phone: _____

Neurologist: _____ Phone: _____

Pulmonologist: _____ Phone: _____

Orthopedist: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Cardiologist: _____ Phone: _____

GI: _____ Phone: _____

Other: _____

a. Does your child have any allergies? [ ] Yes [ ] No

If Yes, please list (Include food and drug allergies): _____

_____

b. Does your child have a history of seizures? [ ] Yes [ ] No

c. Hospitalization (within last 6 months) _____

d. Please list previous hospitalizations and/or surgeries: _____

_____ _____

_____ _____

e. Please list ALL MEDICATIONS your child is currently taking (Include Name, Dosage & Frequency)

_____

_____

_____

_____

f. Please give a brief summary of your child's pertinent medical history: _____

_____

_____

PPEC

EQUIPMENT & SUPPLIES

Child's Name: _____

Does your child eat by? [ ] Mouth [ ] Gastrostomy __ Tube Size [ ] Both

Formula Type: _____ Amount: _____ Frequency: _____

Other: _____

Does your child have any diet restrictions? [ ] Yes [ ] No

If Yes, please explain: _____

Please indicate if your child uses any of the following equipment:

- ☐ Cardiac/Respiratory Monitor
- ☐ Portable Suction Machine
- ☐ Oxygen
- ☐ Nebulizers for aerosol
- ☐ Feeding Pump
- ☐ Gastrostomy
- ☐ Tracheostomy __ Tube Size
- ☐ Wheelchair ☐ Walker
- ☐ Special Seating ☐ Stander ☐ Stroller
- ☐ AFO's ☐ SMO's
- ☐ Braces ☐ Hearing Aide ☐ Glasses

Please indicate last test for:

Hearing: ☐ Yes ☐ No Date & Results: _____

Vision: ☐ Yes ☐ No Date & Results: _____

PPEC

PAST EDUCATIONAL HISTORY

Child's Name: _____

Listed the names of the programs and people that have worked or are working with your child. Please send latest evaluations and/or IEP for your child.

Service	Therapist / Teacher / Program Name	Phone	Dates
Child Care Program			
Early Steps Program			
Preschool			
School			
Occupational Therapy			
Speech Therapy			
Physical Therapy			
ABA			
Infant Learning Program			
Head Start Program			
MSW/Care coordinator			
Dietitian			
Other			
Other			

OTHER: _____

Please described any special needs or concerns regarding your child (such as positioning, feeding, likes and dislikes, etc.)

_____

_____

_____

_____

Peek A Boo Pediatric Care PPEC

CONSENT FOR PLACEMENT AND TREATMENT

I hereby authorized Peek A Boo Pediatric Care PPEC in consent treatment for my child. I understand will provide services for my technologically dependent child. These services include, but are not limited to: developing, implementing and monitoring of a comprehensive protocol of care including medical, nursing, psychological and developmental therapies required by my child.

My responsibilities include providing Peek A Boo Pediatric Care PPEC with the following supplies to be used or consumed by my child while at the center:

- All medical supplies
- Medications
- Diapers
- Wipes
- Food

It is also my responsibility to inform the PPEC of any changes in my child's medical care and of doctor appointments beforehand, if possible.

In case of an emergency, I give permission to the staff of Peek A Boo Pediatric Care to treat my child. If I cannot be reached, I understand that emergency transportation will be provided by a licensed NEMS provider with a Peek A Boo Pediatric Care staff member accompanying my child.

My hospital preference is: _____

I hereby request and give permission for Peek A Boo Pediatric Care to provide medical and psychological examination and treatment as the staff deems best for my child's welfare. This may include an examination by Peek A Boo Pediatric Care's Medical Director to ensure that our quality of service is maintained.

I release Peek A Boo Pediatric Care and staff from any and all liabilities in regard to the care of my child except in the case of gross proven negligence. This authorization will remain in effect for continuing visits until permission is revoked by me.

Parents/Legal Guardian's Name: _____

Signature: _____ Date: _____

Child's Name: _____

Witnessed: _____

PPEC

FINANCIAL AUTHORIZATION

Child's Name: _____ DOB: _____

I understand that the services being provided to my child are not free and accept the responsibility for payment of all or any portion of charges not covered by the authorization set forth below:

1. _____ I authorize Medicaid to billed. ID #: _____

2. _____ I authorize my child's insurance company to be billed.

Insurance Company: _____ Phone: _____

Address: _____

Policy Number: _____ Group Number: _____

Certificate Number: _____

I authorize the release of all records required to act on this request. I request that payment of authorized benefits be made on my child's behalf.

Parents/Legal Guardian's Name: _____

Signature: _____ Date: _____

Witness Signature: _____

Peek A Boo Pediatric Care PPEC

PHOTO PERMISSION SLIP

Dear Parents/Legal guardian:

We would like to take photos of your child: _____
and we would like your permission to include your child in the photos, and/or videos.

Please check the corresponding answer, fill in your child's name, and sign below:

[ ] Peek A Boo Pediatric Care PPEC has my permission to photograph my child.

[ ] I do **not** give Peek A Boo Pediatric Care PPEC permission to photograph my child.

Parents/Legal Guardian's Name: _____

Signature: _____ Date: _____

Witnessed: _____

Peek A Boo Pediatric Care PPEC

PHOTO / TESTIMONIAL / VIDEO RELEASE FORM

I, _____ hereby give **Peek A Boo Pediatric Care PPEC**, its employees unrestricted permission to take, use my name and my child's name, testimonial and/or publish, distribute, project, display photographic images, videos or pictures of my children, whether still, single, multiple, or moving, or in which my child may be included in whole or in part, in color or otherwise, through any form of media (print, digital, electronic, broadcast or otherwise) at any **Peek A Boo Pediatric Care PPEC** center or elsewhere for advertising, recruitment, marketing, fundraising, publicity archival or any other lawful purpose. These photos, videos and testimonials may be used in printed publications, multimedia presentations and on websites.

I waive any right that I may have to inspect and approve the finished product that may be used or to which it may be applied now and/or in the future, whether that use is known to me or my child or unknown.

I release and agree to hold harmless **Peek A Boo Pediatric Care PPEC**, its officers, employees from any liability, any claim or cause of action, by virtue of taking of the pictures or using testimonial.

The person or persons signing this Release represent and covenant that
1) the person or persons signing have full authority in the jurisdiction in which the Release is executed to sign this release on behalf of the Child;
2) the person or persons signing this Release have carefully read the above Release prior to signing, and are fully familiar with the contents and consequences of it;
3) that this release is signed voluntarily under no duress and without expectation of compensation in any form now or in the future; and
4) this Release shall be binding without restriction as to time or otherwise upon the Child and his/her heirs, legal representatives, successors and assigns, as the case may be.

Child's Name: _____

Parents/Legal Guardian's Name: _____

Signature: _____ Date: _____

Witnessed: _____

CHANGE OF CLOTHING AUTHORIZATION

During the day at the PPEC center children may sometimes have little accidents which may require a change of clothes and at time even a bath. In general your child will be encourage to change him/her and a staff will assist if needed. It is necessary however to have permission for staff to help changing and/or bathing if necessary. **Please note that is it necessary to always bring and extra change of clothes for your child to have available during the day at the PPEC center.**

I give **Peek A Boo Pediatric Care** permission for the PPEC staff to change clothing and/or bathe my child in case of an incident, if necessary.

Initials: _____

AUTHORIZATION TO LABEL

I give **Peek A Boo Pediatric Care PPEC** authorization to label my child's clothing and other belongings with a permanent marker in order to prevent loss or inadvertently sending belongings home with another child. The marking will be place on discreet place so as not marc the integrity of the child.

Initials: _____

AUTHORIZATION TO WASH AND DRY CLOTHING

____ I give **Peek A Boo Pediatric Care PPEC** permission to wash and dry my child's dirty clothing at the center

____ I do not give Permission to **Peek A Boo Pediatric Care PPEC** to wash my child's dirty clothing at the center

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PERMIT FOR USING ELECTRONIC DEVICES

I give permission for my child to bring/use an _____(electrical device) and hereby agree that Peek A Boo Pediatric Care PPEC will not be liable for any lost or stolen items.

Child's Name: _____

Parent's Signature: _____ Date: _____

EMERGENCY MEDICAL AUTHORIZATION

In the event that emergency medical attention is required for your child while on the premises of Peek A Boo Pediatric Care, authorization to implement emergency treatment will be required. Please complete and sign statement below.

I, _____ parent/guardian of _____ do hereby give permission to Peek A Boo Pediatric Care, to secure and authorize such emergency medical care and/or statement as above named child might require while under the supervision of assigned center staff. I further authorize Peek A Boo Pediatric Care and/or its responsible staff to represent my child for doctor's appointment and/or medical test, until emergency medical assistance is available. I also understand or testing that I assume any and/or all financial responsibility for expenses incurred during medical treatment for my child. Which may not be covered via the medical health insurance information provided.

Note: 1- This authorization will remain in effect until written notification is submitted to revoke.

2- Every effort will be made to notify parents immediately in case of emergency. In the event there is a delay in reaching the parent/guardian and/or it is deemed dangerous for the child's condition, it will be necessary to initiate emergency response. At such time the following information will be necessary.

Child's Full Name: _____ DOB: _____

Child's Address: _____

Cell #: _____ Other Phone #: _____

Allergies: _____

Medical condition(s): _____

Medical Insurance Information:

Name of Company: _____

Name of Member: _____

Policy Number: _____ Group Number: _____

_____ _____ _____

Signature of Parent/Guardian Relationship Date

SPECIAL CARE SERVICE AGREEMENT

Consent to Treat

I hereby authorize the Peek A Boo Pediatric Care PPEC to render services as prescribed by my child's physician, or any other physician who may be treating my child, including all diagnostic and therapeutic treatments the may be considered advisable or necessary in the judgment of the physician. I hereby release the PPEC from all liability incurred as a result of medical treatment provided by the staff of PPEC**.**

INITIALS: _____

Release of Information

I authorized all physicians, hospitals, clinics and any other health care provider to release medical information from my child's medical records to any licensed institution, case managers, accreditation and regulatory bodies relevant to my child's care at the PPEC. I place no limitations on my child's history of illness or diagnostic/therapeutic information including any treatment for substance abuse, psychiatric disorder or AIDS.
INITIALS: _____

Permission for Disclosure and Use of Information

I consent to the release of my child's PPEC records to be reviewed by authorized representative of Medicaid, and /or my private insurance company(ies) for use in determining my child's health care benefits. Specifically, I authorize the PPEC to allow the individual/PPEC requesting to review my child's medical records to examine my child's personal and medical records. I understand that I have the legal right to refuse the release of my child's personal and medical records now hold by the PPEC. I know that I am waving the legal right by singing this consent. This consent shall be valid for whatever period of time is reasonably necessary for the PPEC requesting to review my records to fulfill the above described purposes, or until I revoke this consent in writing. **INITIALS: _____**

Financial Responsibilities

I understand and accept all financial responsibility for services/supplies provided by the PPEC that are not covered by my child's insurance plan.
INITIALS: _____

Assignment of Benefits

I hereby authorized the PPEC to bill Medicaid for any services provided by the PPEC and to make direct payment to the PPEC for said services.
INITIALS: _____

Personal Valuables

I understand that the PPEC will not be liable for any loss or damage to any money, jewelry, documents, and/or other articles of value.

INITIALS: _____

Statement of Patient Rights and Responsibilities

I certify that I have read, understand and received a copy of the statement of patient's responsibility which have been explained to me orally by a representative of the PPEC. **INITIALS: _____**

Abuse Registry

I certify that I understand their policy and have a copy with the toll free Abuse Registry phone number. **INITIALS: _____**

Advance Directives

I have discussed what actions should be taken in the advent of illness or incapacity with instructions for treatment. **INITIALS: _____**

Medical Emergency

Please note that in case of an medical emergency your child will be taken to _____

By my signature, I attest that I have read and received a copy of the Patient Service Agreement and have had all questions and concerns addressed to my complete satisfaction. I am fully aware that I may contact the PPEC at the phone number listed in this handbook, should any questions/concerns arise while my child is a patient. **INITIALS: _____**

Signature of Parent/Legal Guardian: _____ Date: _____

POLICIES & PROCEDURES FOR PARENTS

The PPEC nursing staff at **Peek A Boo Pediatric Care** strives to provide quality care for your child in a safe environment. The following are processes and procedures which must be followed to ensure your child's quality care in a safe environment. Your adherence to these policies is appreciated.

YOUR CHILD'S PRESCRIBED TREATMENT PLAN

Your child's treatment plan as prescribed by the physician to meet the individual needs of your child. This includes feedings, medications and treatments, therapies including PT, OT, ST and ABA services, as well as such things as G-tube size, tracheostomy size, as applicable. Changes in any of the above cannot be done without a written physician's order.

Your compliance with the prescribed treatment plan will enable your child to reach his or her optimal level of well-being. Deviating from your child's treatment plan may put your child's health in jeopardy, as well as put your PPEC eligibility in jeopardy. We realize there may be changes from time to time. It is your responsibility to obtain a written doctor's order and inform us when these changes occur.

SUSPECTED RISK OF INFECTION

Any child who exhibits signs and symptoms or who is otherwise suspected of having infectious or communicable disease and or is considered to be present significant risk of infection to others will not be allowed to attend the PPEC. If the child is already in attendance at the PPEC he/she will be removed from contact with others and the parent will be notified to pick up their child immediately. The child will be returned to PPEC when the risk of infection is no longer present as evidenced by a written physician statement. Your cooperation will greatly reduce the risk of infection to your child.

MEDICATIONS

In order to safely and accurately ensure that your child receives medications as prescribed all medications administered by the nursing staff must have a written doctor's order and must be labeled appropriately. This includes vitamins, supplements and over-the-counter drugs.

SUPPLIES

Please make sure your child is furnished with all the supplies he/she needs for the day such as feeding supplies, medications, diapers, wipes, adaptive equipment (orthotics, braces, and splints etc). These should be sent from home, unfortunately if we do not have a supply on hand that your child needs, your child will not get it. Discuss with your nurse any questions you may have about what to send to PPEC.

PARENT PICK-UP

We request that you arrive at least 15 minutes before closing to pick up your child. This provides time to gather supplies and talk with the nurse about your child states and allows our stock to leave on time. We do realize that

emergencies can occur. If you are unable to pick up your child as a result of an unexpected emergency, please call us immediately. However if we do not hear from the parent and alternate arrangements are not made, the PPEC staff may be left with no other option but to contact the police department and/or Children & Families.

BUS PICK-UP

All children up to 16 years of age must be restrained in a car seat/child carrier that is crash tested and federally approved. Children 4 years and older, up to the age of 16 years can be restrained by safety/seatbelt if the child is capable of maintaining an upright sitting position. This is in accordance with Florida's transportation/child safety law 316.614. If you are unable to provide an appropriate car seat/child carrier, contact your local law-enforcement agency and they will assist you. Your child will not be transported if they do not have the proper child restraint systems. It is the parent's responsibility to have your child and supplies ready for the bus arrival in the morning. Not having your child ready prolongs the time your child will spend on the bus and delays arrival to the PPEC for needed therapies, treatments, etc. Telephone calls for pick up should not be expected and I was there for emergency use only.

BUS DROP-OFF

It is the parent's responsibility to be home when the bus drops off your child. If an unexpected emergency occurs and this is not possible, please contact us immediately. Please keep in mind that you should allow a window of approximately one half hour before and after the usual drop off time to allow for unexpected (traffic, weather, mechanical breakdown, etc.) conditions. However, if a child cannot be dropped off as a result of a parent not being available at the time of drop off, the child will be returned to the PPEC center prior to closing time. If this is not done, thy PPEC staff may contact the police department and/or Children & Families.

IMMUNIZATIONS

An update immunization record is required for your child's medical record up PPEC and the Dade County Public School Programs at the PPEC as well. Make sure you to obtain **forms 680 and 3040** from your child's pediatrician and send them to the PPEC. Without these forms your child may not receive some services.

CONFIRMATION OF PEEK A BOO PEDIATRIC CARE PPEC POLICIES/PROCEDURES FOR PARENTS

I have received a copy of the Peek A Boo Pediatric Care PPEC policies and procedures for parents and they have been discussed with me. I have read and understood them as outlined and I agreed to comply.

I hereby give consent for my child, _____ to be transported via Medicaid contracted transportation company_____.

I have received a copy of the LogistiCare/Medical Transport Solution Order form for Pediatric Extended Care Paratransit services, which outlines the criteria for my child to be transported.

I hereby give consent for my child, _____ to be treated by D & D Rehab Center for Physical, Occupational, Speech therapy.

I hereby give consent for my child, _____ to be treated by _____ for ABA services.

Printed Name: _____ Date: _____
(Parent/Guardian)

_____ Date: _____
Peek A Boo Pediatric Care Admitting Personnel

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act (HIPPA) of 1996, 45 C.F.R. parts of 160 and 164)

Authorization

I authorize Peek A Boo Pediatric Care PPEC to use and disclose my child's protected health information as described below.

Effective Period

This authorization for release of information covers all past, present and future periods of my child's healthcare.

Extent of Authorization

I authorize the release of my complete health record (including records relating to mental health care, communicable disease, HIV or Aids and treatment of alcohol and abuse.

This medical information may be used by Peek A Boo Pediatric Care PPEC to receive information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect during the entire period of which healthcare is provided.

I understand that I have the right to revoke this authorization, in writing at anytime. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.

I understand that my information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Peek A Boo Pediatric Care PPEC will strive to ensure that patient information is used only for authorized purposes as agreed to by the patient and/or guardian.

_____ _____

Child's Name DOB

_____ _____ _____

Signature of Parent/Guardian Relationship Date

POLÍTICAS Y PROCEDIMIENTOS PARA PADRES

El personal de enfermería de Peek A Boo Pediatric Care PPEC se esfuerza por brindar atención de calidad para su hijo/a en un entorno seguro. Los siguientes son políticas y procedimientos que deben seguirse para garantizar la calidad de la atención de su hijo/a en un entorno seguro. Su adherencia a estas políticas es apreciada.

PLAN DE TRATAMIENTO PRESCRITO DE SU HIJO

El plan de tratamiento de su hijo/a es prescrito por el médico para satisfacer las necesidades individuales de cada niño/a. Esto incluye alimentación, medicamentos, tratamientos y terapias (PT, OT, ST y ABA), así como cambios en el tamaño del tubo de gastrostomía y traqueostomía según corresponda. Los cambios en cualquiera de los anteriores no se pueden realizar sin una orden escrita del médico.

El cumplimiento del plan de tratamiento prescrito le permitirá a su hijo/a alcanzar su óptimo nivel de bienestar. Desviarse del plan de tratamiento puede poner en peligro la salud de su hijo/a así como su elegibilidad para PPEC. Sabemos que pueden haber cambios de vez en cuando por eso es su responsabilidad obtener una orden escrita del médico e informarnos cuando ocurran estos cambios.

SOSPECHA DE RIESGO DE INFECCIÓN

No se permitirá la asistencia al PPEC de ningún niño/a que muestre signos y síntomas de una enfermedad infecciosa o contagiosa pues se considera que presenta un riesgo significativo de infección para los demás niños. Si el niño/a ya está asistiendo al PPEC se separará del resto de los niños y se notificará a los padres para que recojan al niño de inmediato. El niño será devuelto al PPEC cuando el riesgo de infección ya no esté presente como lo demuestra una declaración escrita del médico. Su cooperación reducirá en gran medida el riesgo de infección para su hijo/a.

MEDICAMENTOS

Con el fin de garantizar que el personal de enfermería administre de forma segura y precisa los medicamentos recetados a su hijo/a, estos deben tener una orden escrita del médico y estar debidamente etiquetados. Esto incluye vitaminas, suplementos y medicamentos de venta libre.

SUMINISTROS

Asegúrese de que su hijo tenga todos los suministros que necesita para el día tales como alimentos, medicamentos, pañales y toallitas húmedas, además de equipos de adaptación que incluyen aparatos ortopédicos, férulas, etc. Estos suministros deben ser enviados desde la casa. Discuta con su enfermera cualquier pregunta que tenga sobre qué enviar al PPEC.

RECOGIDA POR PADRES

Para recoger a su hijo/a le pedimos que llegue al menos 15 minutos antes del cierre del PPEC. Esto proporciona tiempo para recoger las pertenencias, hablar con la enfermera sobre el estado del niño/a y permite que nuestros trabajadores salgan a tiempo. Sabemos que pueden ocurrir emergencias, si no puede recoger a su hijo/a como resultado de una incidente inesperado, llámenos de inmediato. Sin embargo, si no recibimos noticias de los padres y no se hacen arreglos alternos, el personal de PPEC no tendrá más opción que ponerse en contacto con el departamento de policía y/o Niños y Familias.

RECOGIDA EN EL AUTOBUS

Los niños hasta 16 años de edad tienen ser asegurados en el asiento del automóvil/portabebés que hayan sido sometidos a prueba de choque y que cuente con la aprobación federal. Los niños de 4 años en adelante y hasta 16 años pueden ser asegurados con el cinturón de seguridad si el niño es capaz de mantener una posición sentada y erguida. Esto es de acuerdo con la ley 316.614 de transporte/seguridad infantil del estado de la Florida. Si usted no puede proporcionar un asiento para el automóvil/portabebés apropiado comuníquese con la agencia policial local y ellos lo ayudarán. Su hijo no será transportado si no tiene los sistemas adecuados de retención-seguridad infantil. Es responsabilidad de los padres tener a su hijo/a y suministros listos para la llegada del autobús. No tener listo a su hijo/a puede prolongar el tiempo que pasará en el autobús, demorando así la llegada al PPEC y comienzo de las terapias y tratamientos necesarios.

LLEGADA DEL AUTOBUS

Es la responsabilidad de los padres estar en casa cuando el autobús deje a su hijo/a. Si ocurre una emergencia inesperada y esto no fuera posible, contáctenos inmediatamente. Tenga en cuenta que debe permitir una ventana de aproximadamente media hora antes y después de la hora de entrega habitual para permitir condiciones inesperadas como tráfico, clima, avería mecánica, etc. En caso de que no se pueda dejar en la casa a su niño/a como resultado de no hay nadie disponible en el momento de la entrega, el niño será devuelto al PPEC antes de la hora de cierre. Si esto no se hace, el personal de PPEC puede contactar al departamento de policía y/o Niños y Familias.

INMUNIZACIONES

Se requiere un registro de vacunación actualizada para el registro médico de su hijo/a en el PPEC. Asegúrese de obtener los **formularios 680 y 3040** del pediatra de su hijo/a y envíelos al PPEC. Sin estos formularios es posible que su hijo/a no reciba algunos servicios.