HORN AND ASSOCIATES IN REHABILITATION, PLLC

2412 Greatstone Point
Lexington, Kentucky 40504
Phone (859) 224-4081

4127 Todds Road
Lexington, Kentucky 40509
Fax (859) 224-4082

www.horntherapy.com

Parent Questionnaire

Today's date:_____

Identifying Information

Client Name:_____ Date of Birth:_____ Gender:_____

Address:_____

Primary Phone:_____ Relationship:_____

Secondary Phone:_____ Relationship:_____

Email Address(es):_____

Parent/Guardian Name:_____ Date of Birth:_____

Address (if different from above):_____

Occupation/Place of Work:_____

Parent/Guardian Name:_____ Date of Birth:_____

Address (if different from above):_____

Occupation/Place of Work:_____

Billing Preference (please circle):

Insurance Private Pay Other:_____

Responsible Party Name and SSN:_____

Insurance Company / Policy Number:_____

Reason for referral / Concerns

_____

_____

Who referred child for services?_____

Physician Name_____

Physician Number and Address_____

Has the child received therapy services in the past?_____

If so, list type of service(s) and length of service(s)_____

Child's school and current grade / daycare_____

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Developmental and Medical History

Was the child born full term? _____ If premature, how many weeks? _____

Please describe pregnancy (any infections or illnesses, stress, complications, medications, etc.)

_____

_____

Please describe labor and delivery (vaginal, Cesarean section, induction, complications, length of labor, etc.)

_____

_____

Please describe any significant neonatal issues (NICU stay, need for oxygen and/or fetal monitor, congenital abnormalities, need for surgery, difficulty with feeding, jaundice, colic, etc.)

_____

_____

Please list history of significant illnesses, surgeries, hospitalizations, etc., such as frequent ear infections, strep throat, gastrointestinal issues, seizures, asthma, allergies, need for ear tube placement, tonsillectomy, etc.

_____

_____

Please list any specialists your child has seen, along with when seen and reason for visit.

_____

_____

Has your child had a hearing evaluation? Please list findings_____

Has your child had a vision screening and/or wear glasses?_____

Please list any medications your child takes_____

Please list any diagnoses your child may have received

_____

To the best of your knowledge, at what age did your child:

Roll over_____ Sit Independently_____ Crawl_____

Stand Alone_____ Walk_____ Go Up and Down Stairs_____

Finger Feed_____ Transition to Solid Foods_____ Transition from Bottle to Cup_____

Use Utensils to Feed Self_____ Toilet Train_____ Sleep through the Night_____

Say First Word_____ Put Two Words Together_____ Follow Simple Directions_____

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Family and Social History

Please list individuals (with their ages and relationship to child) that live in the same home with the child

_____

_____

Do any family members or those living with child have a history of developmental concerns or delays? If so, please list relationship and concern

_____

_____

What is the primary language spoken in the home? _____

Are the any other languages spoken in the home? If so, please list_____

Does your child interact with same-age peers or other children?

_____

_____

Does your child interact well with other children?

_____

_____

What is your child's favorite activities/toys?

_____

Please describe your child's personality and strengths

_____

_____

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2026 Release of Information / Consent to Treatment

Client Name:_____Date of Birth:_____

I hereby authorize Horn and Associates in Rehabilitation, PLLC, to release any information including the diagnosis, records, evaluation rendered to me, and any other information to establish and maintain good care.

Initials are required to disclose privileged information: _____Psychological Records _____Social Service Records

This information may be released to and from (2-way release):

Insurance: **YES__X___**

Physician: **YES_____NO_____**

Physician Name:_____

Physician Address:_____

Physician Phone Number:_____

List any additional people you choose to have access to this information (e.g., other family members, caregivers, health care professionals, teachers, schools)

Name:_____Relationship: School

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

I, or custodial parent/legal guardian, give permission for **Horn and Associates in Rehabilitation, PLLC**, to administer and interpret assessments and/or testing measurements, and/or initiate therapy, and/or seek emergency medical treatment if required.

CONDITIONS

- The patient or legal parent/guardian agrees to authorize the above-named individuals/organization to access his/her confidential health information only for the purposes listed above.
- The information authorized to be released will not be covered under the federal privacy laws.
- The patient or legal parent/guardian agrees that any sharing of confidential health information with individuals/organization listed above may be mailed, faxed, electronically sent and/or hand delivered.
- The patient or legal parent/guardian is voluntarily signing this authorization.
- The patient or legal guardian/parent reserves the right to refuse to sign this authorization.
- The patient or legal guardian/parent reserves the right to revoke this authorization at any time. The revocation must be in writing.
- This authorization will be maintained by Horn andAssociates in Rehabilitation, PLLC, for a period of twelve (12) months.

I agree to the supervised participation of health care learners in my care (e.g., resident students, therapy students, graduate students, other clinical students, etc.) I understand my patient records will be held in strict confidentiality and will not be discussed outside the office._____**(Initials)**

Through my execution of this authorization, I represent that I have legal authority to authorize the foregoing and agree to hold Horn and Associates in Rehabilitation, PLLC, harmless and indemnify from and against any and all losses and/or claims they may suffer by reasons of breach of the foregoing representation.

Telehealth: I understand that telehealth or teletherapy involves the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to receiving health care services to me via telehealth over secure video conferencing platform when applicable._____**(Initials)**

I have read, reviewed, and agree with: Horn and Associates in Rehabilitation, PLLC *Notice of Privacy Practices* and *Disclosure Against Surprise Billing*. A copy of these will be given upon request._____**(Initials)**

Printed Name:_____

Client or Custodial Parent/Legal Guardian Signature:_____Date:_____

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2026 Consent to Leave Voicemail and/or Email

Client Name:_____Date of Birth:_____

Horn and Associates in Rehabilitation, PLLC, staff may contact you be telephone and/or email you with information such as appointment times, insurance, payment, diagnosis, records, examinations rendered to you, and any other information to your voicemail and/or email with your consent.
By signing this "Consent to Leave Voicemail and/or Email," you consent to Horn and Associates in Rehabilitation, PLLC, staff to leave messages and/or email detailed medical information to the phone number(s) and emails below. This information may include, but not limited to, demographic information, billing information, and medical information.

☐ Phone Number(s):_____
☐ Email Address(es):_____
☐ Do not leave any information on any phone number.
☐ Do not leave any information on any email address.

I understand that Horn and Associates in Rehabilitation, PLLC, cannot require me to sign this consent form in order to receive treatment. I understand that I have the right to revoke this consent at any time. This consent is valid for a period of 12 months unless otherwise revoked. A copy of this form will be provided upon request.

Printed Name:_____
Client or Parent/Legal Guardian Signature:_____Date:_____

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2026 OFFICE TERMS AND CONDITIONS

Client Name:_____Date of Birth:_____

Thank you for choosing us for your speech/language, occupational, physical therapy, and/or psychological needs. We are committed to providing you with quality and affordable services. Our office policies are outlined below. Please read, ask us any questions, initial, and sign in the space provided. A copy will be provided to you upon request.

FINANCIAL POLICY

We are happy to send claims to insurance but please keep in mind professional services are rendered and charged to you or the patient and not to the insurance company. If our services are out of network for your insurance, we will be glad to provide you with documentation so you can send claims to your insurance company if you choose.

All patients must complete paperwork and consent forms before seeing the provider. We must obtain a copy of your driver's license/government-issued photographic identification and current valid proof of insurance. **Our office does a courtesy benefit check before your first appointment and at the beginning of the year. A member of the front office will send the primary email address on file your benefit information and estimated out-of-pocket cost. You are responsible for knowing your benefits.** Families are responsible for keeping track of the number of visits, or when and what type of authorization/precertification is necessary. The number of visits and payment of all claims is your responsibility, although we do try to track them as well. _____**(Initials)**

Please remember that precertification and/or authorization is no guarantee of payment from your insurance company. Insurance payments are ordinarily received within 30 days from the time of filing. If your insurance company has not made payment within 45 days, we will ask that you contact your insurance company to make sure payment is expected. We are happy to help you with additional information your insurance company may need to assist in claim payment; however, our office will not enter into a dispute with your insurance company over a claim. If there is no insurance payment activity after 60 days, we will ask for your payment and, of course, reimburse you if your insurance company later pays. _____**(Initials)**

Patient responsibility payments (copays, deductibles, coinsurance, and all outstanding balances) are due at the time of service. Our office accepts cash, checks, MasterCard, Visa, and Discover. **There will be a 3% fee for credit card transactions.** Our preference is to have a credit card or electronic check on file, which will be charged at time of billing, typically within 24-48 hours of the visit. Electronic checks and HSA/FSA cards are not subject to the fee. If you prefer to pay by check/cash, please make arrangements with office staff. If payments have not been made for more than 2 consecutive sessions, without arrangements made with office staff, services will be put on hold until payments are settled. _____**(Initials)**

It is your responsibility to notify our office immediately of any changes in your insurance. Failure to do so may result in your claims being denied and becoming patient responsibility. _____**(Initials)**

Additional documentation (i.e., disability reports/questionnaires, school updates, school conferences, 504 plans, etc.) and extended phone conversations will be provided based on a time-based fee and will be the responsibility of the patient. ____**(Initials)**

ATTENDANCE POLICY

Consistency in attendance to therapy is essential to making and maintaining progress.

Attendance: Regular attendance is expected for therapy. If attendance falls below 75%, you may lose your regularly scheduled therapy time. If you miss more than 3 sessions without 24-hour notice, you may be discharged from therapy services. _____**(Initials)**

Timeliness: If you arrive late for your session, the session may be canceled. Many sessions are scheduled for 30 minutes; if you are 10 minutes late to a session, valuable time is lost, and we are often unable to accommodate. Arriving more than 10 minutes late to a session without prior notification may qualify as a no-show. _____(**Initials)**

Missed Visit Fee: We realize there may be circumstances that require you to cancel your appointment. When these situations occur, please notify the office at least 24 hours prior to your scheduled appointment. With this notice, we may be better able to reschedule your therapy time and/or accommodate others waiting for therapy. Cancelation

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without 24-hour notice will be assessed a $48.00 cancellation fee. If you cancel more than one therapy session with different therapists within the same day and without 24-hour notice, this $48.00 fee will be assessed for each session missed. We understand emergencies do arise; in these situations, notifications are still expected. Emergency situations will be taken into consideration when assessing the cancelation fee. Messages may be left after hours through our voicemail system or email. _____**(Initials)**

SICK POLICY

Please respect the health and wellness of all our clients, staff, and therapists. We expect you to be fever free and symptom free from illness for at least 24 hours to attend therapy sessions. If you have any of the following symptoms, please notify our office immediately: fever, cough, excessive fatigue, or flu-like symptoms.
_____**(Initials)**

I understand that I am responsible for any charges not paid by my insurance coverage and I accept responsibility for any collection costs, attorney fees, and any other cost incurred that may result from nonpayment. I understand and agree to the above terms and conditions. I authorize my insurance company to pay my claims directly to Horn and Associates in Rehabilitation, PLLC.

_____
Printed Name of Client or Parent/Guardian

_____ _____
Client or Parent/Guardian Signature Date

Horn and Associates in Rehabilitation, PLLC

Physical Therapy Questionnaire

Today's Date_____

Child's Name_____ Date of Birth_____

Describe the main physical/motor difficulty in which you are seeking services.

_____

Are there any medical/emotional/environmental factors that you believe contribute to the physical/motor difficulty? If yes, please describe.

_____

Has your child been diagnosed with any condition related to the physical/motor difficulty? If so, please list.

_____

Was your child extraordinarily stiff or floppy as a baby? _____

Does your child seem weaker on one side versus the other side? _____

Does your child have any particular places in his/her body that he/she cannot move freely? _____

Does your child have difficulty with any of the following? (please check):

Head Control	Sitting	Standing	Walking
Rolling	Crawling	Jumping	Holding a Position
Going Up and Down Stairs	Endurance with Activities	Strength	Learning New Movements
Balance	Difficulty Controlling Body	Skipping	Playing on Playground
Throwing/Catching	Riding a Bicycle	Getting In or Out of Positions	

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