Midland CHILDREN'S rehabilitation center

Dyslexia Intake Packet

Date Completed: ______________________

Name of person completing Case History Form: ____

Relationship to child: ____

Language(s) spoken in the home: ____

Language:

____English understood

____Interpreter needed

IDENTIFYING INFORMATION/ FAMILY HISTORY:

Child's Name: Last: ________________________ First: ______________________ MI: ____

Date of Birth: _______________ Age: _______ Gender: ____Male _____Female

Street Address: _______________________________________

City:_______________________________State: _____________ Zip: ____________

Primary Diagnosis: ____

Mother/Guardian's Name: ____ Age: ______

Address: ____

E-mail: ____

Cell #:__________________________________ Home#: __________________________________

Education: _________________________________ Occupation: _________________________

Employer: _________________________________ Work Phone #: _______________________

Work Address: ____

Father/Guardian's Name: ____ Age: ______

Address: ____

E-mail: ____

Cell #:__________________________________ Home#: __________________________________

Education: _________________________________ Occupation: _________________________

Employer: _________________________________ Work Phone #: _______________________

Work Address: ____

Emergency Contact (other than parent or guardian):

Name: ____________________ Phone number:____________________ Relationship:________________

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Demographics

The following information is required. Please answer **ALL** questions. MCRC offers services at no charge to our clients. However, we do have to seek funding from various sources including grants, foundations, and private donors. MCRC needs this information to present a clear picture of the population we serve.

What type of insurance do you currently have?

- ☐ No insurance
- ☐ Medicaid
- ☐ Private Insurance: ____________________
- ☐ SSI/Disability

What is your Annual income?

- ☐ Less than $10,000
- ☐ $10,001-$20,000
- ☐ $20,001-$30,000
- ☐ $30,001-$40,000
- ☐ $40,001-$50,000
- ☐ $50,001-$60,000
- ☐ $60,001-$70,000
- ☐ $70,001-$80,000
- ☐ $80,001-$90,000
- ☐ $90,001-$100,000
- ☐ $100,001 & Over

How many people are in your household? ______

What is the reason you are seeking services at MCRC? (check all that apply)

- ☐ Insurance ran out
- ☐ No longer qualify for Medicaid
- ☐ Do not have private insurance
- ☐ Medicaid is primary insurance
- ☐ Have insurance or other coverage, but prefer to come to MCRC
- ☐ It is the only facility that has the program we need
- ☐ Other_____________________

What is your ethnicity?

- ☐ Asian
- ☐ Black or African American
- ☐ Native American
- ☐ Caucasian (Non-Hispanic)
- ☐ Hispanic/Latino
- ☐ Pacific Islander
- ☐ Others: ____________________

How did you hear about MCRC?

- ☐ Physician
- ☐ Hospital
- ☐ TV
- ☐ Internet
- ☐ Newspaper
- ☐ Employer
- ☐ Facebook
- ☐ Self
- ☐ Friend _______________
- ☐ Other _______________

If you had to pay for tutoring services, what is the approximate cost that your family would incur?

- ☐ $20 Copay per visit
- ☐ $50 Copay per visit
- ☐ $___ Out-of-pocket per visit

Please list your child's diagnoses:

____

____

____

Educational Information:

Child's school: ___________________________________ Phone: ____________________________

Grade: __________ Teacher's Name: ____

Does your child receive special education services, PT/OT/ST? If so, please include length of time per day:

____

If so, how long have you been receiving services?_________ Are services through your child's school? ________

Does your child attend daycare/after school care? ____yes ___no If yes, how many hours a day?_____________

Any customs, religious beliefs, or wishes that we should be aware of?________________________________

MEDICAL/ DEVELOPMENTAL INFORMATION:

Child's Family Physician: ____

Address: ____

Phone: _____________________ Date child was last seen by this physician_____________________

Person who diagnosed your child with Dyslexia: _________________________________

Address: ____

Phone: _____________________ Approximate date your child was diagnosed: _____________________

CONSENT TO TREAT

The State of Texas
County of Midland

WHEREAS, the undersigned are the parent/guardian of

(Child's Name) ____DOB ________________and,

WHEREAS, WE desire that said child shall receive treatment without charge to us or the child at the Midland Children's Rehabilitation Center in Midland, Texas: and, we wish to waive and release any and all claims arising in our favor or in favor of said child in connection with said matter.

NOW, THEREFORE, KNOWN ALL MEN BY THESE PRESENTS: That we hereby request said Midland Children's Rehabilitation Center to furnish treatment for our child. In case of any character of injury or damage to said child growing out of or in said Center, whether the same should occur at the Center or en route to or from the same, we the undersigned, hereby waive and release any and all claim or claims which we or said child may now or hereafter have against any person in anywise connected with said Center or in any way acting for it as a part of its treatment program or in consideration of the treatment therefore given, or to be hereafter given, to said child.

I hereby authorize the above named individual for participation in the following activities if their evaluation indicated the need for this service: medical clinics, wheelchair clinics, orthotic clinics, splinting and casting applications, occupational, speech and/or physical therapy intervention, Dyslexia Tutoring, aquatic therapy, equine assisted therapy and Midland Children's Rehabilitation Center sponsored activities.

Parent/Guardian:____________________________________ Date:_________________

Witness:____ Date:_________________

______ (Initial) Although general referrals to physicians and/or vendors are provided as a courtesy to our clients, MCRC does not endorse any physician or vendor over another. MCRC does not make any representations and cannot be held responsible for any interactions or treatments mutually agreed upon between you and the physician or vendor you choose.

Attendance Policy/Academic Release

Welcome to Midland Children's Rehabilitation Center. We are pleased that your child will be receiving services here at the center.

Midland Children's Rehabilitation Center is a 501(c)(3) non-profit organization supported by the generosity of the citizens of Midland and Texas. The vision of the board of directors is that children with disabilities should receive basic therapy services at *no charge to the children or their families.* For this reason we have an extensive waiting list of children requiring our services. Therefore, **please review the following adopted policy:**

1. **If your child has three No Call – No Show appointments, they may be discharged from tutoring and their slot will be given to the next child on the waiting list**.

   MCRC's Attendance Policy is as follows:
   Each child is required to have an overall attendance rate of 85% for all sessions per discipline seen. If a child has three NCNS's or does not meet the 85% attendance rate, the tutoring slot may be given to the next child on the waiting list and they will be discharged from services. If you are unable to make it to tutoring, you must call ahead of your scheduled appointment or it will be considered a no call – no show.

2. **MCRC will not provide services to children who are currently receiving the same services with any other facility.** If your child is receiving services anywhere else, other than at school, please discuss with your tutor.

3. Parents agree to provide tutors with demographic and academic information deemed relevant by the staff, including but not limited to: attendance, grade promotion, academic skill development and standardized test results.

Parent Signature: ____ Date:________________

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Client Name: ____ DOB: _______________________________

Address: __________________________________ City: ________________ State: ______ Zip: ______________

We are requesting that you authorize the agencies or persons named below to disclose to each other confidential information regarding the above named client.

____ AND ____
Name and Position of MCRC Staff Person/Agency

Midland Children's Rehabilitation Center ______ ____
Name of Person/Agency

Address: 802 Ventura ______________ ____

Midland, Texas 79705 _______ ____

Phone: (432) 498-2053 ________________ ____

Fax: (432) 682-4478 ________________ ____

Records to be released/disclosed: ☐ Evaluation report ☐ Treatment Records ☐ Medical Records
Purpose of release/disclosure:

☐ To provide information pertinent to client's therapy and/or medical treatment.
☐ Other: ____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). 45 CFR §164.508(c)(I)(iii).
I understand that treatment or payment cannot be conditioned on my signing this Authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this Authorization in writing at any time except to the extent that action has been taken in reliance upon the Authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law. 45 CFR §164.508(c)(2)(I); 45 CFR §164.508(c)(2)(ii):
This Authorization will expire One Hundred and Eighty (180) days from the date of my signature below, unless I revoke the Authorization prior to that time or unless specified by date, event, or condition as follows:
___________________________________. 45 CFR § 164.508(c)(1)(v)

Date of Signature:___________________ Signature:____
Patient or legally authorized representative 45 CFR §164.508()(1)(vi)
Printed Name: ____
Relationship to Patient 45 CFR §164.508(c)(1)(iv):_______________
Address:____
Telephone:____

Midland CHILDREN'S rehabilitation center

Family Responsibility Agreement

Client's Name: ____________________________________ Birthday: ________________

Welcome to Midland Children's Rehabilitation Center (MCRC). To make the most out of the services at MCRC, it is important that you understand what we expect of our patients and their families.

Tutor's Responsibilities:

1. Our goal is to instill each client with the skills to achieve academically their very best at home, in school and out in the community.
2. We will use the Barton Reading Program to teach your student and strive to bring them up to grade level reading.
3. We will provide open communication with the family regarding home program recommendations, suggested community services and other professionals that your child might need to see.

Family Responsibilities:

1. Before being seen for tutoring, MCRC **MUST** have a diagnosis of Dyslexia or a recommendation for the specific type of tutoring or testing that is recommended.
2. Be on time to each appointment. If more than 15 minutes late to a session, it will be considered a "No Call – No Show"
3. Parents or guardians will drop off and pick up inside the building unless your appointment time is after 5:30 pm. If your appointment is after 5:30 pm, your tutor will meet you at the east side doors.
4. No cell phone use in treatment areas.
5. Share any changes in information (medical, phone number, address, etc.) with the front staff and Head Tutor.
6. For the best outcome, follow through with home recommendations made by the tutor.
7. To protect privacy, no photography or videos are allowed without proper approval.
8. Complete all mandatory MCRC paperwork and provide any demographic or academic information requested by tutors.

Attendance:

1. If you need to cancel your appointment or are going to be late, please call the office at (432) 498-2053, or call your tutor as soon as possible.
2. Please call to cancel your child's appointment if they have had vomiting, diarrhea, or fever within the 24 hours prior to their appointment.
3. Extended breaks are not permitted—if you must miss more than 3 consecutive weeks of tutoring, your child may be removed from the schedule and their spot given to the next child on the waiting list.

Reasons for Discharge:

1. Noncompliance regarding return of academic information/testing by deadline.
2. All goals set by the tutor at the initial evaluation are reached and tutoring is no longer recommended.
3. A plateau has been made regarding progress towards tutoring goals.
4. Your child misses 3 or more sessions without canceling.
5. Your child does not maintain an attendance rate of 85% for all sessions.
6. The child's behavior prevents their ability to participate and make progress.
7. Your child is receiving services at another facility - MCRC does not duplicate services.

I have read this document and understand my responsibilities and why they are important.

____________________________	______________	____________________________	______________
Parent / Legal Guardian's Signature	Date	Therapist's Signature	Date

Publicity Release for MCRC

Child's Name______________________ Date _________________

_____ I **do not** want my child's photograph to be used in any publicity by the Center.

____ I give my permission to the staff of Midland Children's Rehabilitation Center to utilize facts related to diagnosis and/or for my child to be photographed by the staff of MCRC, Newspaper Photographers and TV reporters for the purpose of: Staff training, fundraising and publicity materials to include but not limited to brochures, slideshows, newsletters, MCRC website, social media, TV and newspaper ads.

Please list any exceptions to the above items where you do not want your child's picture to be included.

This publicity release is granted from the above date and may be revoked or changed by the parent/guardian at any time by submitting a written request to Midland Children's Rehabilitation Center.

I have read and understand this document.

_______________________ _______________________
Parent or Guardian Signature Parent or Guardian Name (Please Print)