

Parent Step-By-Step Guide: Patient Dashboard



Carolina Pediatric Therapy Patient Portal

Click below to open Español version
[Español Version](#)



carolina
Pediatric Therapy
Specialized Pediatric Occupational, Physical & Speech Therapy



Login as Patient

Email Address

Password

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QR Code



Link

<https://bit.ly/CarolinaPeds-PatientDashboard>





Patient Dashboard:

1. Notifications

Complete unsigned patient forms & medical history 48 hrs BEFORE first appointment

2. Appointments

Request, Print, Add to Calendar

3. Billing

Make a Payment, Add Credit Card on File

4. Messages

Communicate with our office

The screenshot shows the Carolina Patient Therapy dashboard. At the top right, it says "Testing IntakeWaitlist (Logged in)" and "McMurry" with a profile icon and "09:43". Below this is a "Change Account" link and a language selector "Cambiar a Español". The main navigation menu on the left includes: Dashboard, Profile, Records, Messages, Notices & Policies, and Settings. The main content area is divided into three columns:

- Appointments:** Labeled with a large number '2'. It shows "No Future Appointment Found" and a button to "Click on the button below to request an Appointment". Below are buttons for "Request Appt", "Print Appointment Card", and "Add To Calendar".
- Billing:** Labeled with a large number '3'. It shows "No pending balance" and a "Make a Payment" button.
- Messages:** Labeled with a large number '4'. It shows "You have no new messages" and buttons for "View All" and "Message the Office".

 A large number '1' with an arrow points to the "Notifications" section at the bottom, which contains four yellow alert boxes:

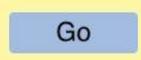
- "Your profile is 20% complete. Finishing it will help us provide better care for you." with "Go" and "Dismiss" buttons.
- "You have some unsigned patient forms. Press 'Go' to see them." with "Go" and "Dismiss" buttons.
- "We don't have your medical history on file. Press 'Go' to navigate to add one." with "Go" and "Dismiss" buttons.
- "Emergency Contact is Required." with "Go" and "Dismiss" buttons.

 A star icon is located between the navigation menu and the notification section.

***DASHBOARD Menu**



Patient Dashboard: How to Complete New Patient Info

1. Check Notifications.
Any in Yellow Need Immediate Attention
2. Select the  button next to the item to complete
3. As you complete the item, Notifications will go away.



Notifications:

Complete missing or unsigned patient forms & medical history BEFORE first appointment

Notifications:

Your profile is 20% complete. Finishing it will help us provide better care for you. [Go](#) [Dismiss](#)

You have some unsigned patient forms. Press 'Go' to see them. [Go](#) [Dismiss](#)

We don't have your medical history on file. Press 'Go' to navigate to add one. [Go](#) [Dismiss](#)

Emergency Contact is Required. [Go](#) [Dismiss](#)

Dashboard tab: *Notifications*



Patient Dashboard: How to Complete Signature Forms



1. Click **Go** button on Notification that says "You have some Unsigned Patient Forms."
2. Unsigned Forms window will pop up.
3. Review Forms or Complete with requested information & Select "I've read and accept this form" for each subsequent form.

Carolina Pediatric Therapy Patient Portal

Testing IntakeWaitlist (Logged in as Summer McMurry)

Change Account: Testing IntakeWaitlist Time: 23:38:07

Dashboard Appointments Billing Messages

Profile Records Messages Notices & Policies Settings

← Policies and Consents

ATTENDANCE & COMMUNICATION POLICY
Effective October 15, 2022

This Policy Notice is a reminder of:

- The importance of consistent attendance to your child's progress.
- The importance of consistent & timely communication with us about your schedule & plans that may affect your child's attendance.
- The importance of family readiness for and commitment to the therapeutic process.
- The consideration of the therapists who plan and reserve space in their schedules for your child.
- The consideration of those in our community who are waiting for care.

This Policy Notice is also to help you understand the reason for this attendance policy and our expectations of communication about your schedule.

Our Expectations of your child's Attendance and Communication with us about your child's schedule:
Ideally, your child attends all of their scheduled/reserved sessions. However, to allow for unexpected life events of patients and therapists, our attendance policy is that **your child may miss no more than two (2) sessions each treatment plan cycle without rescheduling.**

To protect our providers' time and ensure your child makes progress:

- More than two missed appointments without rescheduling a make-up visit will result in dismissal from therapy and penalty fee charged.
- Reschedules may need to be with another team therapist if your child's primary therapist does not have a spot to reschedule, with the exception of some behavioral health appointment types.
- Missing an appointment without prior communication (no show) is grounds for immediate dismissal from services and referral back to your child's primary care provider.
- No Shows will result in a communication non-compliance penalty fee charged.

Print

I've read and accept this form

***Notifications: Unsigned Forms**



Patient Dashboard: How to Complete Signature Forms



1. After final form has been acknowledged,
Add YOUR Electronic Signature on File

IMPORTANT: This should be **YOUR name** as the signer and Authorized Representative/Parent/Legal Guardian of the child. This Should NOT be the child's name. Children cannot sign consent forms.

2. Click the **Finish & Save** button

The screenshot shows a mobile application interface for signing forms. At the top, there is a blue header with a back arrow and the text "Signature". Below the header, there is a "Signer Name" field containing the text "Type Testing Parent Name". A grey arrow labeled "1" points to this field. Below the name field is a section titled "Electronic Signature" with a blue underline. Inside this section is a text area containing the following text: "I am electronically signing these forms that I have marked as accepted and acknowledging that I have read the forms and agree to the terms and conditions, and warrant that all the information that I supplied on these forms is true, accurate, current and complete. I confirm that I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature." At the bottom of the form, there is a "Finish & Save" button with a floppy disk icon. A grey arrow labeled "2" points to this button.

***Notifications: Unsigned Forms**

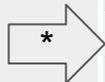


Patient Dashboard: How to Complete Pediatric Medical History

Before you begin:

Important:

- This History Form is comprehensive.
- Set aside **5-15 minutes of uninterrupted time** to complete it. Depending on complexity of your child's condition it could take less or more time.
- A Computer with Chrome browser provides the best experience, but you can complete it on a tablet or smartphone



Carolina Pediatric Therapy Patient Portal

Test SLI (Logged in as Summer McMurry) Time: 17:06:23

Change Account Test SLI Time: 17:06:23

Cambiar a Español Logout

We don't have your medical history on file. Please click on the button to add one.

Edit	Last Updated	Description

Add Pediatric History

*Records tab: *Medical History* Subtab

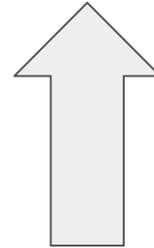
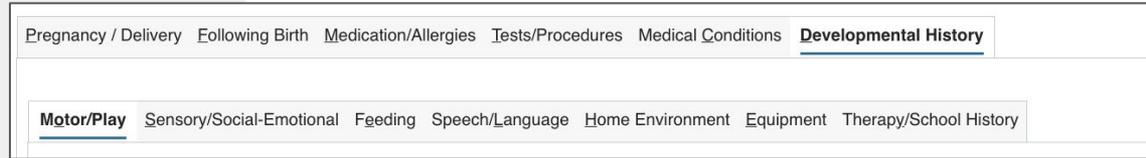


Patient Dashboard: How to Complete Pediatric Medical History

Reminders while completing:

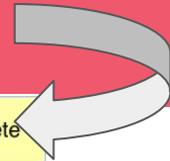
Important:

- Click through and **Complete ALL 6 Tabs and 7 Sub-tabs** under the Developmental History Tab.
- This **MUST** be complete at least **48 hours BEFORE** your Scheduled Evaluation Appointment.
- Incomplete History may require us to reschedule your Evaluation to a later date.



Complete ALL Tabs BEFORE selecting
Save and Close History Button

Click to Save and Close History Once Complete





Patient Dashboard: How to Complete Pediatric Medical History

1. Select **Add Pediatric History** button
2. This will open up the *Pediatric History Form*



Carolina Pediatric Therapy Patient Portal

Test SLJ (Logged in as Summer McMurry)

Change Account: Test SLJ | Time: 17:08:23

Cambiar a Español | Logout

We don't have your medical history on file. Please click on the button to add one.

Edit	Last Updated	Description
------	--------------	-------------

Add Pediatric History

*Records tab: *Medical History* Subtab



Pediatric History: Tabs 1-3

← Medical History: Please complete this History First

INSTRUCTIONS: For Parents & Authorized Legal Representatives completing New Patient forms on our Patient WebPortal: *Please complete each tab on this Medical History form before you complete Patient Forms to be Signed. *To advance through each tab, click the NEXT button at the bottom of the tab. *On the last tab, click the SAVE button, or the yellow button on the right to save and close.

Click to Save and Close History Once Complete

Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions Developmental History

Pregnancy Proceeded Delivery Proceeded

Length of Pregnancy Delivery Was

Prenatal Care Visits Child's length of hospital stay

Pregnancy Complications

<input type="checkbox"/> Ectopic	<input type="checkbox"/> Positive for strep B
<input type="checkbox"/> Gestational diabetes	<input type="checkbox"/> Pre-eclampsia
<input type="checkbox"/> Multiple births	<input type="checkbox"/> Premature labor
<input type="checkbox"/> Polyhydramnios	<input type="checkbox"/> Substance exposure
<input type="checkbox"/> Positive for cytomegalovirus "CMV"	<input type="checkbox"/> Toxemia
<input type="checkbox"/> Positive for herpes	<input type="checkbox"/> Other: please specify <input type="text"/>
<input type="checkbox"/> Positive for HIV	

Delivery Complications

<input type="checkbox"/> Abruptio placenta	<input type="checkbox"/> Transverse presentation
<input type="checkbox"/> Breech presentation	<input type="checkbox"/> Proapsed cord
<input type="checkbox"/> Low birth weight	<input type="checkbox"/> Use of forceps
<input type="checkbox"/> Negative vacuum	<input type="checkbox"/> Uterine rupture
<input type="checkbox"/> Non-progressive/unproductive labor	<input type="checkbox"/> Umbilical cord around the neck
<input type="checkbox"/> Occiput posterior position (Face up)	<input type="checkbox"/> Other: Please specify <input type="text"/>
<input type="checkbox"/> Placenta previa	
<input type="checkbox"/> Premature rupture of membranes	

Birth Information

Mother's Age at Time of Birth years

Birth Weight lbs oz

Birth Height ins

Needed to be Transferred to Another Hospital Yes No

Transfer Hospital

1 min 5 min 10 min

Multiple Child Pregnancies

Please add any other comments regarding pregnancy or birth:

Number of live births: Number of still births:

Additional details of birth:

Pregnancy/Delivery

← Medical History: Please complete this History First

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Click to Save and Close History Once Complete

Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions Developmental History

Yes No

<input type="checkbox"/> Anemia of prematurity	<input type="checkbox"/> IVH Bleed Grade I	<input type="checkbox"/> Neonatal hypoxia
<input type="checkbox"/> Bronchopulmonary dysplasia "BPD"	<input type="checkbox"/> IVH Bleed Grade II	<input type="checkbox"/> Oxygen dependency
<input type="checkbox"/> Cleft lip	<input type="checkbox"/> IVH Bleed Grade III	<input type="checkbox"/> PDA
<input type="checkbox"/> Cleft palate	<input type="checkbox"/> IVH Bleed Grade IV	<input type="checkbox"/> Positive dependency
<input type="checkbox"/> Club foot	<input type="checkbox"/> Jaundice treated with photo-light therapy &/or bilirubin blanket	<input type="checkbox"/> Respiratory distress syndrome
<input type="checkbox"/> Cytomegalovirus	<input type="checkbox"/> Meconium aspiration	<input type="checkbox"/> Respiratory stridor
<input type="checkbox"/> ECMO	<input type="checkbox"/> Necrotizing enterocolitis "NEC"	<input type="checkbox"/> Respiratory syncytial virus "RSV"
		<input type="checkbox"/> Retinopathy of prematurity "ROP"
		<input type="checkbox"/> Thrombocytopenia (Low Platelet Count)
		<input type="checkbox"/> Ventilator dependency
		<input type="checkbox"/> VP Shunt

Following Birth

← Medical History: Please complete this History First

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Click to Save and Close History Once Complete

Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions Developmental History

Medication/Allergies

Hearing Testing

Last Test Date

Results

Concerns

Vision Testing

Last Test Date

Results

Concerns

Medications/Allergies



Pediatric History: Tabs 4-6 (subtab 1)

← Medical History: Please complete this History First

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Click to Save and Close History Once Complete

Pregnancy / Delivery Following Birth Medication/Allergies **Tests/Procedures** Medical Conditions Developmental History

Physicians				Surgeries/Procedures	
Name	Specialty	Reason	Date of last visit	Type of surgery	Date

Diagnostic Tests

Date last performed	Details/results

Comments (5)

Tests/Procedures

← Medical History: Please complete this History First

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Click to Save and Close History Once Complete

Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures **Medical Conditions** Developmental History

Does the child have:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Chronic Ear Infections	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Shunts
<input type="checkbox"/> Aortic/venous malformation "AVM"	<input type="checkbox"/> Celiac	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Torticollis
<input type="checkbox"/> Atoxic brain injury	<input type="checkbox"/> Constipation	<input type="checkbox"/> Periventricular Lukomatosis	<input type="checkbox"/> Traumatic brain injury "TBI"
<input type="checkbox"/> Asthma/respiratory breathing problems	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Reflux	<input type="checkbox"/> Tube feeding
<input type="checkbox"/> Autism	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Seizure Condition	<input type="checkbox"/> Tubes in ears
<input type="checkbox"/> Backflow pump	<input type="checkbox"/> Hip subluxation	<input type="checkbox"/> Scoliosis Degrees? <input type="text"/>	<input type="checkbox"/> Vagal nerve stimulator
<input type="checkbox"/> Cerebral Palsy "CP"	<input type="checkbox"/> Hydrocele	<input type="checkbox"/> Sleep disorder	
<input type="checkbox"/> Cerebral Vascular Accident "CVA"	<input type="checkbox"/> Laryngomalacia	<input type="checkbox"/> Sleep problems	

Comments (5)

Medical Conditions

← Medical History: Please complete this History First

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Click to Save and Close History Once Complete

Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions **Developmental History**

Motor/Play Sensory/Social-Emotional Feeding Speech/Language Home Environment Equipment Therapy/School History

When did the child begin:

Bringing both hands to mouth	Began at age: <input type="text"/>
Buttoning particle/it	<input type="text"/>
Come to sitting from lying without assistance	<input type="text"/>
Crawling or crawling alone	<input type="text"/>
Fully toilet trained	<input type="text"/>
Grabbing a toy	<input type="text"/>
Holding head up alone	<input type="text"/>
Pulling self to standing position	<input type="text"/>
Rolling over	<input type="text"/>
Self-bathing	<input type="text"/>
Self-dressing	<input type="text"/>
Sitting alone without support	<input type="text"/>
Standing unsupported	<input type="text"/>
Tying shoes	<input type="text"/>
Walking with support	<input type="text"/>
Walking unaided	<input type="text"/>
Zippering/unzipping jacket	<input type="text"/>

Comments/Concerns

Is the child

Right-handed Left-handed No hand preference

Are there concerns about handwriting? Yes No

Please describe:

Description of Child

<input type="checkbox"/> Active	<input type="checkbox"/> Motivated	<input type="checkbox"/> Curious
<input type="checkbox"/> Affectionate	<input type="checkbox"/> Passive	<input type="checkbox"/> Demanding
<input type="checkbox"/> Aggressive	<input type="checkbox"/> Persistent	<input type="checkbox"/> Difficult to Comfort
<input type="checkbox"/> Calm	<input type="checkbox"/> Playful	<input type="checkbox"/> Distractible
<input type="checkbox"/> Cautious	<input type="checkbox"/> Shy	<input type="checkbox"/> Other: Please specify <input type="text"/>
<input type="checkbox"/> Fearless	<input type="checkbox"/> Stubborn	
<input type="checkbox"/> Fussy	<input type="checkbox"/> Withdrawn	
<input type="checkbox"/> Insecure	<input type="checkbox"/> Fearful	

Developmental History
Motor-Play



Pediatric History: Sub Tabs 2-4

← Medical History: Please complete this History First

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Click to Save and Close History Once Complete

Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions **Developmental History**

Motor/Play Sensory/Social-Emotional Feeding Speech/Language Home Environment Equipment Therapy/School History

Sensory Processing/Regulation

Select all that Apply

- Avoids getting messy
- Seeks out (grazes) touch or movement
- Stumbles or falls frequently
- Appears awkward or less coordinated
- Flips hands
- Allows brushing of teeth
- Bangs on surface, bangs/kicks head
- Fatigues quickly
- Has self-abusive behaviors
- Resists certain tasks or environments
- Spins things or self
- Is sensitive to lights, sounds or noise
- Sleeps a lot
- Resists touch
- Walks on toes
- Lines up toys or objects
- Seeks out (grazes) visually stimulating objects
- Seeks out (grazes) stimulating sounds
- Resists certain movements (e.g. bouncing, swinging, upside down)

Has difficulty figuring out how to move body or takes more time with movements

Does not tolerate certain textures (e.g. clothing, surfaces, foods, toys, etc)

Uses a lot of pressure when touching someone or holding object

Has difficulty transitioning from one activity to another

Has difficulty falling asleep

Has difficulty remaining asleep through the night

Appears lethargic/sleepy at the time

Has poor sense of body in space, runs into things

Seeks support for posture (e.g. leans on furniture, walls or people, tocks head)

Demonstrates stiff or rigid movement patterns

Hyperfocused (on specific tasks, people, objects, etc)

Other: Please describe

Social/Emotional Skills

Select all that Apply

- Is easily distracted
- Calms self easily
- Gets angry/frustrated easily
- Is aggressive towards others
- Prone to emotional outbursts
- Doesn't allow others to join in play
- Has difficulty making friends
- Plays with peers
- Only plays with adults
- Prefers to play alone
- Has difficulty with separations
- Has poor eye contact
- Other concerns:

Developmental History
Sensory/Social-Emotional

← Medical History: Please complete this History First

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Click to Save and Close History Once Complete

Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions **Developmental History**

Motor/Play Sensory/Social-Emotional **Feeding** Speech/Language Home Environment Equipment Therapy/School History

Current feeding concerns

Describe Any Feeding Problems (S):

Food preferences are:

Food dislikes are:

When did the child begin:

Using a Bottle: Stop Using a Bottle:

Using a Pacifier: Stop Using a Pacifier:

Eating Baby Food: Using Utensils to Eat:

Eating Junior Food: Holding Own Bottle/Cup:

Eating Table Food: Self-feeding:

Drinking From a Cup:

Drinking From a Sip Cup:

Using a Straw:

Breast Feeding

Currently
Times per day:

Weaned

At age:

Never

Area of Difficulty

- Chewing
- Drooling
- Communicating Needs
- Swallowing
- Transitioning Between Foods
- Understanding Words
- Jaw Shifts/Sidebites/Juts

Current feeding adaptations

- Thickened liquids
- Adapted Utensils
- Adapted Seating
- Calorie Supplements
- Tube Feeding

Please specify:

Details:

Details:

Details:

Amount: Times per day:

Developmental History
Feeding

← Medical History: Please complete this History First

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Click to Save and Close History Once Complete

Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions **Developmental History**

Motor/Play Sensory/Social-Emotional Feeding **Speech/Language** Home Environment Equipment Therapy/School History

Communication Skills

Does the child:

Have speech that is understood by most people? Yes No

Respond correctly to yes/no questions? Yes No

Follow simple instructions? Yes No

Respond when name is called? Yes No

Stutter? Yes No

Recognize objects, people, and places? Yes No

When did the child begin:

Babbling: Putting 2 words together:

Saying first words: Using short sentences:

Naming familiar objects:

First Words:

Is an augmentative communication device used?

Details:

The child's primary method of communication is:

Details:

Verbal Communication

Select the primary methods of verbal communication used:

- None
- 2 word phrases
- Vocalizations
- Complete sentences
- Single word phrases

Non-Verbal communication

Select the primary methods of non-verbal communication used:

- Facial expressions
- Gestures
- Body Language
- Pointing
- Manual Sign Language
- Eye Gaze

Communication concerns:

Developmental History
Speech-Language



Pediatric History: Sub Tabs 4-7

← Medical History: Please complete this History First

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Click to Save and Close History Once Complete

Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions **Developmental History**

Motor/Play Sensory/Social-Emotional Feeding Speech/Language **Home Environment** Equipment Therapy/School History

Child lives with

Select all that apply:

- Birth Mother Adoptive Mother
- Birth Father Adoptive Father
- Step-mother
- Step-father
- Grandmother
- Grandfather
- Siblings Please list sibling ages: _____
- Other relative Please specify: _____
- Legal guardian Please specify: _____

Comments/Other Details: _____

Adoption

Age of child at adoption: _____

Please provide additional details of adoption (e.g. country, child's prior living situation, etc.): _____

Type of home

- Single Level Home Assisted Living Facility
- 2 Level Home Skilled Nursing Facility
- Ground Floor Apartment Group Home
- Upper Level Apartment Other: _____

Accessibility

- Stairs to get into Home How Many? _____ Handrail?
- Ramp to get into Home
- Stairs in Home How Many? _____ Handrail?
- Bathroom on Main Level Bedroom on Main Level
- Bathroom on Upper Level Bedroom on Upper Level

Comments: _____

Developmental History
Home Environment

← Medical History: Please complete this History First

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Click to Save and Close History Once Complete

Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions **Developmental History**

Motor/Play Sensory/Social-Emotional Feeding Speech/Language Home Environment **Equipment** Therapy/School History

Equipment

Please select all that apply:

Approx. age of equipment	Details	Used at Home	Used at School/Day Care
<input type="checkbox"/> Braces		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walker		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stroller		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Manual Wheelchair		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Power Wheelchair		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hooyer Lift		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Weighted Vest		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand Sprinkler(s)		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Track System		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____		<input type="checkbox"/>	<input type="checkbox"/>

Do you currently perform a home program with the child? (e.g. stretching, strengthening activities, brushing, etc) Yes No

If yes, please describe what you do: _____

Is the child involved in any community groups or sports activities? Yes No

If yes, please provide more details: _____

Comments: _____

Developmental History
Equipment

← Medical History: Please complete this History First

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Click to Save and Close History Once Complete

Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions **Developmental History**

Motor/Play Sensory/Social-Emotional Feeding Speech/Language Home Environment Equipment **Therapy/School History**

Grade in School: _____ Where: _____

Does your child have an I/SP? Yes No

Does your child have an IEP from school? Yes No

Has your child had a psychological or neuropsychological evaluation completed? Yes No

Other Services

Type	Status	How Often?	Where?
<input type="checkbox"/> Assistive Technology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Audiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Behavior Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Developmental Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> EI Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Intensive Ssl Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vision Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Social Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Speech / Language Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Developmental Follow-up Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments (8): _____

Developmental History
Therapy/School History

Last Step

Click to Save and Close History Once Complete



Patient Dashboard: How to Complete Profile

1. Review Your Child's Personal Information for Correctness.
2. If incorrect, **Message Us** with correction.
3. Patient phone numbers **should be blank** because our patients are minors and do not receive calls or texts from our office.
4. All contact updates will be done on *Contact Info* tab for the **Authorized Representative: Adult Caregiver/Parent**.

The screenshot shows the 'Carolina Pediatric Therapy Patient Portal' interface. The user is logged in as 'Systems Raintree'. The main navigation menu includes Dashboard, Profile, Records, Messages, Notices & Policies, and Settings. The 'Profile' tab is active, and the 'Personal Info' sub-tab is selected. The form contains the following fields:

- Title: First Systems, MI, Last Raintree
- DOB: 04-01-2012, Age: 13 yrs 0 mos
- Birth Sex: Male (selected), Female
- Social Security #: [Redacted]
- Mailing Address: 345 Testing Ave, City: Orlando, State: FL, Zip: [Redacted]
- Preferred language: [Dropdown]
- Physical Address: 12345 Testing Ave, City: Orlando, State: FL, Zip: [Redacted], County: Orange
- Race: Black Or African American (selected), show extended list [checkbox]
- Ethnicity: Hispanic Or Latino (selected)
- Home Phone: (655) 445-3342, OK To Call: [checked], Best Time To Call: Anytime
- Work Phone: [Redacted]
- Cell Phone: (951) 446-1236
- How did you hear about us?: [Redacted], Please Specify: [Redacted]

A 'Save and Return to Dashboard' button is located at the bottom right of the form.

***Profile Tab: Personal Info Sub Tab**



Patient Dashboard: How to Review & Update Contact Info

1. **Review** Registered Contacts.
2. **Message** the office to update any contact information for Registered Contacts
3. **Review and add/update:**
 - a. Referring Doctor
 - b. Primary Care Physician
 - c. Emergency Contact
 - d. Any Additional Contacts
4. Once Added, select **SAVE and Return to Dashboard** button

Carolina Pediatric Therapy Patient Portal

Systems Raintree (Logged in as Systems Raintree)

Change Account Systems Raintree Time: 16:20:26
Cambiar a Español Logout

Message the office to update any contact information

Referring Doctor
First Name _____ Last Name _____
Address _____
City _____ State _____ Zip _____
Phone _____
Fax _____

Primary Care Physician
First Name _____ Last Name _____
Address _____
City _____ State _____ Zip _____
Phone _____
Fax _____

Patient Employer
Name _____
Address _____
City _____ State _____ Zip _____
Phone _____
Occupation Owner Work _____

Emergency Contact
First Name _____ Last Name _____
Address _____
City _____ State _____ Zip _____
Home _____ Cell _____
Type _____

View Additional Contacts Record

Registered Contacts

Name	Phone	Work/Fax	Cell	Type of Contact	Flags
Keili Paru	(555) 445-3342		(111) 222-3333	Professional C...	Authorized Representative
Test Test	(111) 111-1111			Professional ...	Emergency Contact

Professional Contact Emergency Contact Family Contact

Save and Return to Dashboard

***Profile Tab: Contact Info Subtab**



Patient Dashboard: How to Add Other Contacts

1. **Add** additional contact persons here.
2. **Add anyone who may bring your child to therapy other than you.**
 - a. Include address
 - b. Include cell phone
 - c. Include email address
 - d. Mark as Authorize Representative
 - e. Emergency Contact
3. Once added all additional contacts, select **SAVE** button.

The screenshot shows the 'Contact Info' subtab for 'Contact 1'. The form includes the following fields and options:

- Contact Type:** Contact Additional (dropdown)
- First Name:** Test (text), **MI:** (checkbox), **Last Name:** Test (text)
- Address:** (text)
- Address 2:** (text)
- City:** (text), **State:** (dropdown), **Zip:** (text)
- Home Phone:** (111) 111-1111 (text), **OK To Call:** (checked checkbox), **Best Time To Call:** (dropdown), **Preferred:** (radio button)
- Work Phone:** (text), **OK To Call:** (checkbox), **Best Time To Call:** (dropdown), **Preferred:** (radio button)
- Cell Phone:** (text), **OK To Call:** (checkbox), **Best Time To Call:** (dropdown), **Preferred:** (radio button)
- Fax:** (text)
- Email Address:** (text)
- Authorized Representative:** (checkbox), **Preferred language:** (dropdown)
- Emergency Contact:** (checked checkbox)

Patient Information:

Patient	Systems Raintree	MR #	000002	DOB	04-01-12	Age	13
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Save button

Numbered arrows indicate the following steps:

- 1:** Points to the 'Contact Type' dropdown.
- 2a:** Points to the 'First Name' field.
- 2b:** Points to the 'Home Phone' field.
- 2c:** Points to the 'Cell Phone' field.
- 2d/e:** Points to the 'Authorized Representative' and 'Emergency Contact' checkboxes.
- 3:** Points to the 'Save' button.

Profile Tab: Contact Info Subtab



Patient Dashboard: How to Add & Update Insurance Info

1. **Review your Primary & Secondary Insurance Information** by clicking the tabs
2. **Message** the office to update insurance info
3. **Upload front & back of insurance card** for all insurance policies that cover your child

The screenshot shows the 'Carolina Pediatric Therapy Patient Portal' interface. At the top, it says 'Systems Raintree (Logged in as Systems Raintree)' and 'Time: 16:47:10'. There are buttons for 'Cambiar a Español' and 'Logout'. The main content area has tabs for 'Primary (A)', 'Secondary (B)', 'Tertiary (C)', and 'Patient Self Pay (P)'. The 'Primary (A)' tab is selected. The 'Insurance Info' subtab is active in the left sidebar. The form contains the following fields:

- Insurance type: Medicaid (dropdown), Effective date: 01-01-08
- Insurance address: PO Box 30968, City: Raleigh, State: NC, Zip: 27622, Insurance phone: (empty)
- ID #: TESTING, HMO?: No (selected), Yes (radio button)
- Group: (empty)
- Copay Type: Copay/Visit (radio button), Copay/Day (radio button)
- Copay Amount: (empty), with instructions: 'If you have a fixed dollar amount per visit, enter that amount here OR If you are responsible for a percentage of the services, enter that percentage (please include the % sign)'
- Insured Information: Patient Relationship to Insured* (Self dropdown), First: Systems, Last: Raintree, Address: 345 Testing Ave, City: Orlando, State: FL, Zip: (empty), Phone: (555) 445-3342, DOB: 04-01-2012, Gender: Male (radio button), Female (radio button, selected)

At the bottom of the form, there are two buttons: 'Upload Insurance Card' and 'Save and Return to Dashboard'.

***Profile Tab: Insurance Info Subtab**



Patient Dashboard: How to Upload Card

1. Select **Upload Insurance Card** button
2. Secure Message will open
3. Select **Upload** button
4. **Browse** to select Card image
5. Select Category dropdown
 - a. "Insurance Card Front"
6. Select **Add Another Upload** button
7. **Browse** to select Card image
8. Select Category dropdown
 - a. "Insurance Card Back"
9. Select **Send Message** button

Your card will be sent directly to your
child's patient chart!

The screenshot shows the patient dashboard interface. On the left, there is a form for patient information with fields for Insurance address, City, ID #, Group, Copay Type, and Copay Amount. Below this is the 'Insured Information' section with a dropdown for 'Patient Relationship to Insured' set to 'Self'. A blue button labeled 'Upload Insurance Card' is highlighted with a white arrow labeled '1'. To the right, a 'Secure Message' window is open, displaying a message from 'Tech Support' with instructions to 'Take a good well centered picture' and 'Click Upload to complete'. Below the message is a 'Browse...' button. At the bottom of the secure message window, there is a 'Select Category *' dropdown menu with 'Insurance Card Front' selected. A white arrow labeled '3 & 6' points to this dropdown. A 'Add Another Upload' button is also visible.

Profile Tab: *Insurance Info* Subtab



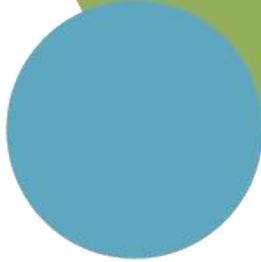
Patient Dashboard: How to Upload Documents

1. Select **Open Secure Message and Upload Documents** button
2. Secure Message will open
3. Select **Upload** button
4. **Browse** to select a document
5. Select Category dropdown
6. Select **Send Message** button

Your document will be sent directly to your child's patient chart!

The screenshot shows the Carolina Pediatric Therapy Patient Portal interface. The top navigation bar includes the logo and the text "Carolina Pediatric Therapy". The user is logged in as "Systems Raintree". The main content area displays a grid of menu items: Dashboard, Medical History, Profile, Patient Forms, Records, Allergies, Messages, Patient Education, Notices & Policies, and Upload Documents. A blue button labeled "Open Secure Message and Upload Documents" is highlighted with a large arrow labeled "1". Below this, a "Secure Message" window is open, showing a message from "Tech Support" with instructions to upload a document. A "Browse..." button is highlighted with a large arrow labeled "4". At the bottom of the message window, there is an "Upload" button (arrow "3"), a "Send Message" button (arrow "6"), and a "Close" button. A category dropdown menu is open, showing options like "Child's Profile Picture", "Document", "Insurance Card Back", and "Insurance Card Front", with "Document" selected (arrow "5").

*Records Tab: Upload Documents Subtab



Thank you!

Please reach out to us with any questions!
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