Account #:_____

PEDIATRIC REGISTRATION UPDATED
(CONTINUING PATIENT)

Date:_____

Patient Name:_____ DOB:____/____/____ Age:_____
LAST FIRST MI MO DAY YR

Address:_____ City:_____ State:_____ Zip:_____

Contact Phone: (___)_____-_____ Social Security Number:_____-_____-_____

Parent/Guardian Name(s) and Phone #'s:_____

Are parents: □ Married □ Separated □ Divorced ☐Other_____

E-Mail Address: _____

Referring Physician:_____ Phone: (___)_____-_____

Primary Care Physician:_____ Phone: (___)_____-_____

Emergency Contact :_____ Phone: (___)_____-_____

Relationship to patient:_____

Other individuals authorized to bring child to therapy (please list names and contact info)

_____

*PLEASE LIST AGAIN ON SIGNED CONSENT FORM

Goals for Child (Physical Therapy – Gross Motor):_____

_____

Goals for Child (Occupational Therapy – Fine Motor/Activities of Daily Living):_____

_____

Goals for Child (Speech/Language Therapy)_____

_____

Favorite Toys/Activities: _____

UPDATED FAMILY HISTORY:

Sibling Name	Age	Sex

Other individuals living in the home: _____

Parent/Guardian Occupation(s):_____

Have any family members had any speech, language, hearing problems, behavioral, mental health or learning difficulties? ☐ No ☐Yes Describe:_____

What languages are spoken in the home?_____

Was this child adopted (or in foster care)? ☐No ☐Yes
If Yes, at what age? _____From Where?_____

Recent Medical History (please list history from the past 12 months)

Recent Surgical/Hospitalizations (e.g., PE tubes, tonsils/adenoids removed)
List all surgeries or hospitalizations (list dates):_____
_____

Recent Medications
List all medications and/or supplements:_____
_____

Allergies
List all known drug allergies, food allergies/restrictions, environmental allergies:_____
_____
_____
Is child allergic to latex: □ Yes □ No

Recent Medical Tests (list date of test)
Has child had: □ X-rays □ MRI □ CT Scan □ Swallow Tests □ Other_____
Results:_____

Recent Medical Evaluations
Previous medical evaluations including neurological, physiological, cardiac or educational:_____
_____
□ Name of Dr./Therapist:_____
□ Date of exam:_____
□ Institute:_____
□ Outcome:_____
□ Other Diagnoses:_____

Recent Therapy History
Has child had previous: □ Physical Therapy □ Occupational Therapy □ Speech Therapy
If so, when?_____ Where?_____ For how long?_____
Outcomes:_____

Current Schooling
Present School:_____ Grade:_____
Is child receiving services in school? □ Yes □ No If so, what services?_____
Is there an Individualized Educational Program (IEP) in place? □ Yes □ No
If so, do you have a copy? □ Yes □ No

Updated Vision/Hearing
List any visual or hearing problems/concerns:_____
Does child wear glasses? □ Yes □ No Contacts: □ Yes □ No
Does child have ear tubes? □ Yes □ No Hearing Devices: ☐ Yes ☐ No
Has hearing and vision been tested recently? ☐ Yes ☐ No When? Results? _____

Current Equipment
Who is the vendor(s) for equipment? _____
□ Walker □ Crutches □ Loft-Strand Crutches □ Wheelchair □ Braces:_____
□ Communication Device: _____□ Other:_____

Consent For Treatment

I hereby give consent to Capitol Physical Therapy Associates, Inc. and its designated agents to provide evaluative and treatment services as necessary and reasonable for my child's care.

_____ _____

Signature Date

Authorization to Release Medical Information for Insurance

I hereby authorize Capitol Physical Therapy Associates, Inc. to release any information necessary to process this claim.

_____ _____

Signature Date

Authorization to Release Medical Information to Family/Non-Family Members

I understand that my child's medical information is confidential and can not be released without my authorization. I also understand that I may not always be able to bring my child to his/her therapy sessions. I authorize the following individuals to bring my child for their therapy treatments and give permission to the following individuals to obtain applicable information from CAPTA regarding my child's therapy, both verbal and written and can sign for consent if medically necessary:

Name:_____ Relationship:_____ Phone: (___) ____-____

Name:_____ Relationship:_____ Phone: (___) ____-____

Billing Policy

Capitol Physical Therapy Associates, Inc. as a service to our patients will submit your claim to your insurance company. Capitol Physical Therapy Associates, Inc. participates with most insurance companies *(see below). You are responsible for any copays and/or deductible according to your individual policy. Please check with your insurance company for the details of your policy since ultimately you are the person responsible for the cost of treatment. As payments are received by us from your insurance company, we will bill you for any copays or deductible that may apply. Please make payment as you receive each bill. A billing fee of $4.00 will be added for every duplicate statement sent for unpaid balances. If you know that paying your balance will be a hardship, please contact our billing office to work out payment arrangements. If it becomes evident that no effort is being made towards payment, your bill will be turned over to a collection agency. I have read and UNDERSTAND the above and agree to accept responsibility for any balance on my account that is not payable by my insurance company. I give Capitol Physical Therapy Associates, Inc. permission to bill my insurance company on my behalf.

_____ _____

Signature Date

*Not all insurance companies are willing to pay for rehabilitation services at Capitol Physical Therapy Associates, Inc. Again, please check with your insurance company regarding any stipulations.

Acknowledgement of Notice of Privacy Practices

I have received and read the Notice of Privacy Practices of Capitol Physical Therapy Associates, Inc. You may request a copy.

_____ _____

Signature Date

This policy has been established to help us serve you and your child better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of health care to other patients.

A "no-show" is missing a scheduled appointment. A "late-cancellation" is canceling an appointment without calling us within 24 hours in advance of an office visit.

We understand that situations such as medical emergencies and sickness occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis. However, if your child is too ill to participate in treatment or may be contagious, please cancel your appointment. If you or your child arrives ill, you will be dismissed and charged a fee of **$25.00** for the session.

Because this office holds a time for your session, you are essentially promising to fulfill that slot. Consistent attendance is essential in order for your child to make progress in treatment sessions. If you exceed a cancellation rate of 25 percent or higher you will receive a written notice that your slot is in jeopardy, especially if you do not attempt to schedule or attend make-up sessions. This policy includes emergency, non-emergency and vacation cancellations.

A charge of **$25.00** will be assessed for each no show or late cancellation office visit appointment if less than 24 hours notice is given.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

_____ _____

Signature Date