



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.

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Signature

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Date