FYZICAL Pediatrics Mid-Michigan

Account #: _____

PEDIATRIC THERAPY 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:

Name: _____ Phone: (____) ____-____ ☐ Parent ☐ Guardian

Name: _____ Phone: (____) ____-____ ☐ Parent ☐ Guardian

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 the child to therapy (please list names and contact info)

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

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

How would you like to receive reminders about your appointment? Text Message ☐ Phone Call ☐ Email ☐

**PLEASE LIST AUTHORIZED INDIVIDUALS AGAIN ON SIGNED CONSENT FORM*

DATABASE

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	Gender

Account #: _____

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?

_____

What is the primary language used with this child?

_____

Is/was this child adopted (or in foster care)? ☐ Yes ☐ No

If Yes, at what age? _____ From Where? _____

RECENT MEDICAL HISTORY (please list history from the past 12 months)

Recent Surgical/Hospitalization History (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 the child allergic to latex? ☐ Yes ☐ No

Recent Medical Tests (list dates of tests):

Has child had: ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Swallow Tests Other _____

Results: _____

Recent Medical Evaluations
Previous evaluations including neurological, physiological, cardiac or educational:

_____

Name of Dr./Therapist: _____

Date of exam: _____

Institute: _____

Outcome: _____

Other Diagnoses: _____

Recent Therapy History

Has the child had previous: ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy
☐ ABA/behavioral therapy Other _____

If so, when? _____ Where? _____ For how long? _____

Outcomes: _____

Current Schooling

Present School: _____ Grade: _____

Is child receiving services in school? ☐ Yes ☐ No If so, what service? _____

Is there an Individualized Educational Program (IEP) in place? ☐ Yes ☐ No

Account #: _____

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 (Type) _____

☐ Communication Device (Type) _____ Other: _____

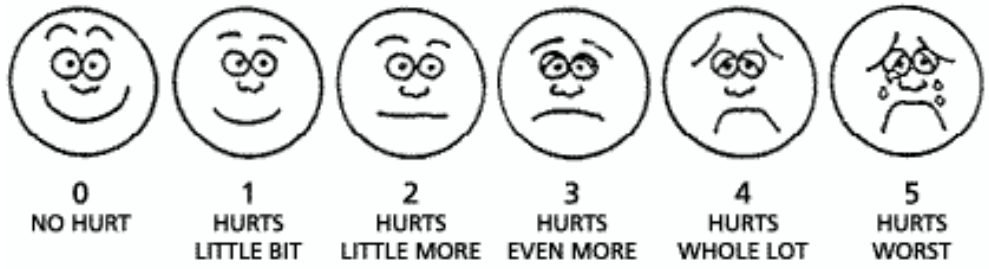
Current Pain Assessment

Does the child appear in or complain of pain? ☐ Yes ☐ No

If so, where? _____

How does the child display signs of discomfort? _____

Can the child express his/her own pain or discomfort using the faces below? Mark one



0 1 2 3 4 5

Account # _____

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

CAPITOL AREA PHYSICAL THERAPY ASSOCIATES Inc.

d.b.a. FYZICAL Therapy Mid-Michigan Pediatrics

Pediatric Authorization form to use or disclose Protected Health Information (PHI)

Please print:

Patient Name: _____ DOB: _____

☐ I'm authorizing the person/organization listed below to receive or acquire Protected Health Information from Capitol Area Physical Therapy Associates, Inc.

List below the person or name of the organization you are authorizing to make the requested uses or disclosures. (Please include the recipients name, phone and e-mail address).

Name/Agency: _____ Phone: _____ E-Mail: _____

Name/Agency: _____ Phone: _____ E-Mail: _____

Name/Agency: _____ Phone: _____ E-Mail: _____

Please specify the records you wish to have. Check all that apply.

- ☐ Therapy Evaluation
- ☐ Progress Notes
- ☐ Prescriptions/Plans of Care
- ☐ Daily Treatment Records
- ☐ Exercise Flow Sheets
- ☐ Discharge Notes
- ☐ Billing Records

Other Instructions/Comments:

_____

_____

_____

The starting date and ending date of your request: From: _____ To: _____

Your signature: _____ Date: _____

Are you the patient listed above? ☐ Yes ☐ No

If no to the above; Describe your authority to act as the patient's representative:.

_____

_____

Your signature above affirms you have read and agree to the following: You have the right to revoke authorizations not prohibited In the Privacy Notice. In order to do so you must submit your request in writing.. This authorization cannot be combined with any other authorization except for authorizations conditioned on the provision of treatment Your authorization allows Capitol Area Physical Therapy Associates, Inc. and staff to use or disclose protected health information you have described. If this disclosure includes copying of the patient chart, the entire contents of the medical record will be disclosed, including records from other entities unless specifically restricted by the requester or by law. You may be charged copying fees as outlined by the Medical Records Access Fee Schedule. Your authorizing includes transmission of the medical records by fax unless you specify otherwise in the description space.

FYZICAL
Pediatrics Mid-Michigan

Account # _____

This policy has been established to help us serve you and the 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 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 the 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 the 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