

PEDIATRIC THERAPY REGISTRATION

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 GuardianName: _____ Phone: (____) ____ - ____ Parent GuardianAre 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*Have you been seen at a CAPTA/FYZICAL Pediatric clinic before? Yes No

How did you hear about CAPTA/FYZICAL Pediatrics?

Returning Patient Family/Friend Web-Site Newspaper Ad Physician Recommend Facebook TV Ad Mailing **DATABASE****Chief Complaint/Reason for Referral:**_____
_____**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:**_____

Family History:

Account #: _____

Sibling Name	Age	Gender

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? _____

Pregnancy/Prenatal History

Age of Mother (during pregnancy): _____

Mother's general health: _____

Pregnancy Complications: _____

Natal History

Child's Birth Weight: ____ lbs ____ ozs

Length of Pregnancy (full term/preterm): _____

Birth Order: single twin A twin BDelivery: vaginal forceps vacuum assist caesarean section breech

Complications during birth: _____

Postnatal History Intensive Care (NICU) needed? Yes No Length of stay: _____

Any health problems or medications the first 2 weeks of life? _____

Ventilation Required: Yes No Oxygen Required: Yes No Amount: _____Transfusions/Phototherapy: Yes No Types: _____Concern or trouble regarding feeding (in infancy)? Yes No**Past Medical History**

History of: Seizures Asthma Thyroid Respiratory infection
 Cardiac Reflux Ear Infection Sensory Concerns
 Picky eating Cancer Kidney Stones Neurological Problems

Other: _____

Past Surgical/Hospitalization History (e.g., PE tubes, tonsils, adenoids removed)

List all surgeries or hospitalizations (list dates): _____

Medications (List all medications and/or supplements):

Account #: _____

Allergies (List all drug allergies, food allergies/restrictions, environmental allergies):

Is the child allergic to latex? Yes No

Medical Tests (list dates of tests)

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

Results: _____

Evaluations

Previous evaluations including neurological, physiological, cardiac or educational:

Name of Dr./Therapist: _____

Date of exam: _____

Institute: _____

Outcome: _____

Other Diagnoses: _____

Therapy History

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

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

Outcomes: _____

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

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: _____

Growth & Development

Gross Motor Skills: At what age did child perform activities? (Or indicate typical/delayed)

Roll	_____	Jump/hop	_____
Sit Alone	_____	Climb Stairs	_____
Crawl	_____	Walk backward	_____
Run	_____	Ride Bike	_____
Stand Alone	_____	Skip/Gallop	_____
Walk Alone	_____		

Fine Motor Skills: At what age did child perform activities? (Or indicate typical/delayed)

Eat with fingers	_____	Use Utensils	_____
Drink from cup	_____	Scribble/Draw	_____
Use a straw	_____	Cut with scissors	_____
Stack Blocks	_____	Use toilet	_____

Dominant Hand Preference: Left Right Both

Check if appropriate: Trips often Clumsy Afraid of heights/climbing Avoids uneven surfaces

Activities of Daily Living:

To what extent does the child perform the following activities?

	Independent	Mild Assist	Moderate Assist	Complete Assist
Wash/bathe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dress/undress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Button/zip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tie shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brush teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Feeding:

Does the child have difficulty sucking, swallowing, chewing, or eating different textures?

- Yes No Describe: _____
- Strong food preferences
- Avoids/dislikes certain foods

Speech and Language:

At what age did the child perform activities? (or indicate typical/delayed)

Activity	Age
Babbling (e.g., "ba, ba")	
Use first words	
Put 2-3 words together	
Put sentences together	
Engage in conversation	

- Does your child have difficulty expressing needs/wants? Yes No
- Is the child's voice hoarse or husky? Yes No
- Can the child follow simple commands? Yes No
- Can the child follow complex commands? Yes No
- Does the child have difficulty answering questions? Yes No
- Is the child's vocabulary limited? Yes No

If yes, approximately how many words is child using? _____

Does the child stutter? Yes No Describe: _____

How does the child usually communicate (check all that apply)?

- Gestures Crying Leading Single words Short phrases Sentences

Approximately how much of the child's speech do you understand?

- Less than 10% 25% 50% 75% 90%-100%

Approximately how much of the child's speech do those less familiar with the child understand?

- Less than 10% 25% 50% 75% 90%-100%

Please indicate when/if the child stopped:

Activity	Age stopped
Using pacifiers?	
Using bottles?	
Thumb sucking?	
Nursing?	

Social/Play/Acedemic Skills:

How does the child play with other children (cooperative, leader, lone, aggressive, passive, etc):

Does the child engage in conversation or verbally interact with peers? Yes No

Does the child make friends easily? Yes No

Does the child need to be in control? Yes No

List any concerns you may have about the child's social/play skills:

Any academic or learning concerns? Yes No

Describe: _____

Behavioral Characteristics

- | | | |
|--|---|--|
| <input type="checkbox"/> No Specific Problems | <input type="checkbox"/> Stubborn | <input type="checkbox"/> Destructive/aggressive |
| <input type="checkbox"/> Easily Frustrated | <input type="checkbox"/> Short Attention Span | <input type="checkbox"/> Separation Difficulties |
| <input type="checkbox"/> Difficult to Discipline | <input type="checkbox"/> Plays Well with Others | <input type="checkbox"/> Easily Distracted |
| <input type="checkbox"/> Poor eye contact | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Willing to try new activities |

Does your child express frustration related to communication or motor skills? Yes No

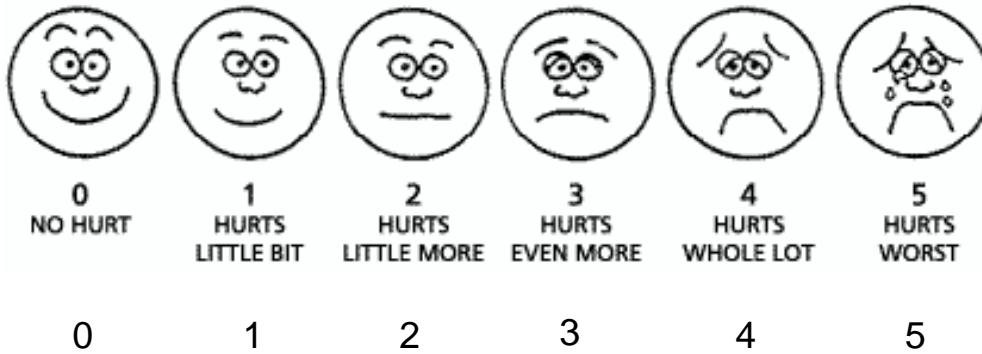
Pain Assessment

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



Consent For Treatment

I hereby give consent to Capitol Physical Therapy Associates, Inc. (D.B.A. FYZICAL Therapy Mid-Michigan) 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

Exercise Flow Sheets

Progress Notes

Discharge Notes

Prescriptions/Plans of Care

Billing Records

Daily Treatment 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.

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