OT/PT Pediatric Registration Form

Child Name: _____ DOB/Age:_____

Gender: M /F School:_____ Grade:_____

Parents/Guardian Name:_____

Marital Status (Please circle): married divorced separated domestic partnership single

Home Address: _____

Mobile Contact Number: _____

Email address:_____

Contact person in case of emergency:_____

Phone Number: _____

Physician Information: *Please provide a prescription from your physician for OT &/or PT evaluation.

Referring Physician:_____

Address:_____

Phone Number :_____

Primary Care Physician (if different from above): _____

Phone Number:_____

Insurance Information: *Please provide your current insurance identification card to the front desk.

Name of Insured:_____

Relationship to the child:_____

Insured's Address:_____

City, State, Zip Code:_____

Insured's Social Security Number:_____

Insured's Date of Birth:_____

Name/Type of Insurance Carrier:_____

ID #:_____ **Group #**:_____

Secondary Insurance: _____

ID #:_____ **Group #**:_____

Are you aware of your deductible and co-insurance responsibility? Yes No

OT/PT Pediatric Intake Form

Child Name: _____ DOB/Age:_____

Child lives with: _____

Siblings name and age:_____

How did you hear about this pediatric program?_____

Who referred your child for an OT/PT evaluation?_____

Diagnosis:_____

Parent/Guardian Concerns/Reason for visit:_____

_____

Does your child currently receive therapy (OT, PT, Speech, Behavioral, ABA, Counseling etc)?
Yes or No If yes, what therapy and where (private &/or school) _____

_____

Past evaluations & date:_____

Past and current medications (including vitamins, and/or supplements):_____

_____

Does your child have seizures? Yes or No If yes, when was the last incident_____

Allergies:_____

Past surgeries & date:_____

Birth History

Child was born: full-term or premature, If premature, how many weeks? _____

Delivery: vaginal, with forceps, C-section, Breech _____

Was your child placed in the newborn intensive care unit? Yes or No, If yes, how long?_____

Additional comments regarding pregnancy, childbirth or other significant medical information:

_____

_____

Developmental History

At what age did your child begin to or complete the following:
Rolled::_____ Sat alone: _____ Crawling (on hands & knees): _____ Pulled to stand: _____
Walked alone: _____ First Word: _____ Combined Words/Talked: _____

Additional comments regarding motor and language development:_____

_____

_____

Current special equipment your child uses: (ie AFO's, walker, communication device, adaptive equipment etc):_____

_____

Vision

Does your child have a visual impairment? Yes or No _____
Does he/she wear glasses? Yes or No _____
Name of eye doctor (optometrist/opthmalogist):_____
Last eye exam: _____
Additional Comments:_____

_____

Hearing

Has your child ever had P.E. tubes? Yes or No _____
Has your child's hearing ever been tested? Yes or No _____
Do you feel your child hears normally? Yes or No _____
Additional Comments:_____

_____

Feeding/Diet

Is your child on a special diet plan? Yes or No _____
Food allergies: _____
Any feeding or nutritional concerns? _____

_____

Social/Behavior

Does your child interact well with others? Yes or No _____
Does your child have any trouble making friends? Yes or No _____
Does your child have difficulty calming himself/herself when upset? Yes or No_____
If yes, what calms your child?_____
Does your child tolerate changes in routine? Yes or No _____
Does your child transition well from one activity to another? Yes or No _____
List any significant events/changes in the home (death in the family, divorce, move, family discord etc): _____
Additional Comments:):_____

Activities of Daily Living (ADL's)

Please mark the following that are most difficult for your child to perform independently:

Eating with utensils ___ Cup Drinking ___ Toothbrushing ___ Bathing ___ Hand washing ___

Face washing ___ Dressing (shirt) ___ Dressing (pants) ___ Socks ___ Shoes ___

Zippering ___ Shoelace tying ___ Buttons ___ Snaps ___ Toileting ___ Hair brushing ___

Additional Comments: _____

_____

_____

_____

What activities or toys are motivating for your child? What does he/she enjoy doing?

_____

_____

_____

_____

What activities or toys does your child avoid or dislike?

_____

_____

_____

_____

What are your child's strengths?_____

_____

_____

What is your GOAL that you would like your child to achieve during therapy treatment?

_____

_____

_____

_____

Patient Authorization

Assignment of Benefits: I hereby authorize Active Physical Therapy/OT Time, LLC (Provider) to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to Provider. I understand that I am ultimately responsible for the occupational therapy and/or physical therapy charges, and I agree to pay my deductible, co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on occupational therapy and/or physical therapy treatment. I understand that I am responsible for knowing and meeting the requirements of my insurance plan.

Payment Responsibility: I understand that I am responsible for all occupational and/or physical therapy bills incurred through the services of Provider and I authorize payment to all occupational therapy and/or physical therapy benefits for services rendered. **I understand that I may receive insurance checks in the mail and understand that it is my responsibility to bring the checks to the front desk. Please contact the front desk with any questions.**

Release of Information: I authorize Provider to release medical or other information necessary to process claims payable for services rendered. I also authorize the release of any information pertinent to my child's case to any insurance company, adjuster, or attorney involved in this case. I also give permission for Provider to share medical information such as evaluations, re-evaluations, and/or progress notes to my child's physician(s).

Privacy Policy Acknowledgment: I have reviewed the sign explaining the Notice of Privacy Practices.

Cancellation Policy: I acknowledge that I may be billed $75.00 for cancellations made within 24 hours of scheduled appointments and no-show appointments.

Informed Consent for Evaluation/Treatment: I consent to the evaluation and treatment of my child by Provider. I agree that I have been fully informed and understand all information relevant to the evaluation/treatment of my child by the Provider.

Emergency Medical Release: I give my permission to the Provider to contact emergency personnel in the event of a medical emergency.

_____ _____ _____

Please print: First name Middle name Last name

_____ _____

Parent/Guardian Signature Date