PEDIATRIC INTAKE FORM (1/6)

Patient Info

Name: _____ Today's Date: _____/_____/_____
First MI Last

( ) Male ( ) Female Date of Birth: ____/_____/_____ Student Status: ( ) Full-Time ( ) Part-time ( ) N/A

Name of child's school: _____ Grade_____

Parent/Guardian Name:_____ Relationship to patient: _____
First MI Last

Home Address: _____
Street Address City State Zip Code

( ) Home or ( ) Cell (_____) _____-_____ ( ) Work or ( ) Cell (_____) _____-_____

Email Address: _____

How would you like to receive appointment reminders? ( ) Text( ) Email ( ) No Reminders Needed

Do you give permission to leave a message on your answering machine? ( ) Yes ( ) No

Emergency Contact: _____ _____ Ph: (_____) _____-_____
Name Relationship to patient

Physician Info

Referring Physician: _____ Date of Next MD Appt: _____/_____/_____

Primary Care Physician: _____

Other Specialists: _____ Type: _____

Other Specialists: _____ Type: _____

Family Info

Child lives with: ( ) both parents ( ) one parent: _____ ( ) other: _____

First Parent/Guardian's Occupation: _____ First Parent/Guardian's Age: _____

Second Parent/Guardian's Occupation: _____ Second Parent/Guardian's Age: _____

Are there other adults living at home: Yes ( ) No ( ) _____

Primary language spoken at home: _____

Name of Siblings	Gender	Age	Medical Diagnoses, Therapies Received

*Bay State Physical Therapy; MCR Chiropractic; MVPT Physical Therapy; Cypress Physical Therapy

PEDIATRIC INTAKE FORM (2/6)

Consent to Treat

I, the undersigned, give Bay State Physical Therapy and its affiliates* my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, my condition may worsen, or new symptoms may develop on rare occasions. I also understand that no guarantee or promise has been made to me concerning the results of treatment. Lastly, I understand that common areas are accessed by other patients, gym members and guests and as a result, there may be incidental contact with personal health information.

Signature: _____ Date: _____

(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under the age of 18): O Mother O Father O Legal Guardian

Ack of Notice of Privacy Practices & Release of Information

I, the undersigned, acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understand the notice. Bay State Physical Therapy and its affiliates* reserve the right to modify the privacy outlined in this notice.

Signature: _____ Date: _____

(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under the age of 18): O Mother O Father O Legal Guardian

I understand that Bay State Physical Therapy and its affiliates* may use or disclose my Personal Health Information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payments. I further understand I have the right to restrict how my PHI is used and disclosed for treatment, payment, and administrative operation if I notify the practice. I also understand that Bay State Physical Therapy and its affiliates* will consider requests for restriction on a case by case basis but does not have to agree to requests for restrictions.

I hereby authorize one or all of the designated parties listed below to request and receive the release of any PHI regarding my treatment, payment or administrative operations related to my treatment and payment. I also understand that the identity of the designated parties must be verified before the release of any information. Please provide the name(s) of the individual(s) who you will allow to receive any part(s) of your health record.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under the age of 18): O Mother O Father O Legal Guardian

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PEDIATRIC INTAKE FORM (3/6)

Photo Release

( ) I consent to pictures being taken for the purpose of home exercise programs and caregiver education
( ) I consent to pictures being used for HEP / caregiver education and on the company website / social media
( ) I do not want any pictures taken of this child

Patient's Name: _____ DOB: _____

Signature: _____ Date: _____
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under the age of 18): O Mother O Father O Legal Guardian

No Shows/Cancellation Policy

In order for you to have the best possible outcome from your treatment, it is essential that you attend all of your appointments. Missing scheduled appointments greatly hinders progress toward your goals and may result in delaying your recovery. We respectfully require a 24 hour notice for any appointment cancellation which allows us the best opportunity to accommodate another patient requiring treatment. We reserve the right to charge a missed visit fee if less than 24 hours notice is given. Exceptions would be emergency, illness or inclement weather.

DO NOT CANCEL if you are feeling worse or believe the treatment is not working. Please understand that your pain will fluctuate as your course of treatment progresses. Keep your appointment and discuss any changes with your PT or DC.
DO NOT CANCEL if you are feeling better; keep your appointment in order to progress your plan of care & prepare for discharge.

Thank you for your cooperation with this policy. Signing below indicates that you understand and agree to the terms of this policy.

Signature of Person Responsible for Charges: _____ Date: _____
(Parent or Legal Guardian must sign if patient is under 18 years of age)
Relationship to Patient: (If patient is under the age of 18): O Mother O Father O Legal Guardian

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PEDIATRIC INTAKE FORM (4/6)

Financial Responsibility

As a service to our patients, we will verify your benefits with your insurance company. It is, however, **the patient's responsibility to be aware of their in-network /out of network options as well as the contractual agreement they have with their insurance company** per their policy. It is the patient's responsibility to initiate a referral when it is required.

Patients MUST immediately report to us any changes to their insurance plans. Any denials in services already provided as a result of failing to report changes will be the financial responsibility of the patient. Although we make every effort to assist our patients in dealing with their insurance companies, we cannot serve as negotiators of the contract between these two parties. Ultimately, it is the patients' responsibility to resolve any insurance denials directly with their insurance company when the denial is through no fault of our practice.

I understand and agree that insurance claim forms will be submitted to my insurance company on my behalf as a matter of convenience only and that I am responsible for all charges regardless of my existing medical coverage. I also understand that I am responsible for any out-of-pocket costs such as copays, deductibles, coinsurances & medical supplies. I also understand that copays are due at the time services are rendered & any medical supplies must be paid for the same day.

I hereby give authorization for payment of insurance benefits to be made directly to Bay State Physical Therapy & its affiliates* for services rendered. In the event that my insurance company forwards payment directly to me, I will immediately deliver said payment to the clinic where services were rendered.

I understand & agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I further understand that by not addressing my balance beyond the second billing cycle may subject my account to collections actions. I understand and agree that if it becomes necessary for Bay State Physical Therapy and its affiliates* to utilize an outside collection agency or to commence court action for the collection of any outstanding charges, I will be responsible for the outstanding balance as well as attorney fees, court costs and any other related expenses.

I agree to the release of medical and other information necessary to process my claim.

I understand that any unsettled balances from a previous case must be resolved prior to returning to care.

Returned Check Policy: Any checks returned for insufficient funds will immediately be subject to a $30 processing fee in addition to the value of the check. Patients with a returned check fee will not be permitted to use this form of payment going forward for products and services.

Signature of Person Responsible for Charges: _____ Date: _____

(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under the age of 18): O Mother O Father O Legal Guardian

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BAY STATE PHYSICAL THERAPY MCR CHIROPRACTIC MVPT PHYSICAL THERAPY Cypress PHYSICAL THERAPY

PEDIATRIC INTAKE FORM (5/6)

Medical History

Mother's health during pregnancy: Excellent Good Fair Poor

Complications: _____

Medications taken: _____

Pregnancy Duration _____ Birth Weight _____

Special Considerations

Prolonged labor _____ Induced _____ Breech _____ Premature _____

Multiple Birth (i.e., twins) _____ Caesarean _____ Vacuum/forceps _____

Baby's health at birth: Excellent Good Fair Poor

Please include any additional information such as: color, jaundice, anoxia, breathing problems, incubator, NICU stay etc.:

_____

_____

Does this child have any medical diagnoses (ADHD, Cerebral Palsy, Autism etc.)?_____

_____

Hearing: Has your child's hearing been tested? Yes No

Does your child have / had PE tubes Yes No

If yes, date inserted _____ Date removed _____

Vision: Has your child's vision been examined? Yes No

Findings: _____

Does your child wear glasses? Yes No

Allergies?_____

Current Medications

( ) Check if medication list is attached – if so, skip this section

Medication Name	Dosage	Frequency	Route (oral, topical, etc.)	Reason

Milestones

At what age did your child

First sit?_____ First crawl?_____

First stand?_____ First walk?_____

Is your child potty trained? If yes, at what age? _____

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PEDIATRIC INTAKE FORM (6/6)

Additional Medical History

	Yes	No	Age	Additional Details
Ear Infections				
Frequent colds/sinus Infections				
Tonsils/adenoids removed				
Seizures/convulsions				
Asthma				
Hospitalization				
Surgery/Botox				
Head Injury				
Feeding Tube				
Broken bones				
Sprains/Strain				
Leg braces/orthotics/casts				

Goals for Therapy

Has this child received therapy in the past or are they receiving therapy currently? Yes No

If yes, what type of therapy, frequency, location? _____

_____

Does this child have an IEP? Yes No If yes, what type of special services, frequency, duration? _____

_____

_____

Does this child use any special equipment (wheelchair, assistive device, compression garments, splints, braces)? _____

_____

_____

What are the goals you would like to see accomplished in therapy? _____

_____

Is there any other pertinent information you would like us to know? _____

_____

The above information is true to the best of my knowledge.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under the age of 18): O Mother O Father O Legal Guardian

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