Pediatric Patient Information

Patient Name: ______________________ Social Security #: ______________

Address (Street): ______________________ Birthdate: __________ Sex: ❑ Male ❑ Female

Address(City, State,Zip): ______________________ Email: ______________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Marital Status: ❑ Single ❑ Divorced ❑ Married ❑ Widowed

Person Responsible for Charges

If person responsible for payment is different from patient, please complete below:
If patient is a child please indicate if parents are: ❑ Married ❑ Separated ❑ Divorced

Name: ______________________ Social Security #: ______________

Address (Street): ______________________ Birthdate: ______________

Address(City, State,Zip): ______________________ Phone #: ______________

Employer: ______________________ Employer Phone #: ______________

Employer Address: ____

Referral Information

Primary Care Physican: ______________________ Referring Physician: ______________

Accident Information

Is your injury the result of an accident? ❑ Yes ❑ No If so, please complete the section below. _____

Date of Accident: ______________________ How did it happen? ❑ Auto ❑ Work ❑ Other

State in which injury occurred? ______________ Insurance Company: ______________________

Claim #: ______________ Claims Adjuster: ______________ Phone #: ______________

Address: ____

Emergency Information

In case of emergency notify - Name: ______________________ Relationship: ______________

Address: ______________________________________ Phone: ______________

Insurance Information

Primary Insurance		**Secondary Insurance**	
Insurance Name		Insurance Name	
Policy/ID #		Policy/ID #	
Group/Account #		Group/Account #	
Policy Holder's Name		Policy Holder's Name	
DOB		DOB	
Social Security #		Social Security #	
Relation to Patient		Relation to Patient	

Notification of Patient Responsibility

Mountain River Physical Therapy LLC verifies your benefits with your insurance carrier but does not guarantee any information given to us regarding benefits, authorization or network plan. We request that you check with your health plan for a complete understanding of what will be billed to you. If the information provided by your insurance company or by you is not accurate or the insurance company changes its coverage, you will be responsible for payment for services.

Based upon the information that your insurance company quoted to us, your benefits are as follows:

Deductible: __________________ Co-Insurance: ____________________ Co-Pay: ______________________

Benefit Description: ____

____

Financial Responsibility and Assignment of Benefits

I understand that insurance billing is provided as a courtesy and that I am financially responsible to Mountain River Physical Therapy LLC for all charges arising from my treatment. *We do not bill tertiary carriers. It is my responsibility to notify Mountain River Physical Therapy of any changes in my health care coverage. While Mountain River Physical Therapy verifies benefits with my health plan, exact insurance benefits cannot be determined until the health plan receives the claim. I agree to accept financial responsibility for all medical services or supplies provided to me. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. If any law, such as worker's compensation or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases or any other type of information necessary to allow for

speedy collection from my third-party payor. I understand that if I have a remaining balance after 60 days my account may be placed with an outside collection agency. * We accept payment by cash, check, Visa, Mastercard or Discover.

Notice of Privacy Practices

I hereby acknowledge that I have received or declined a copy of the Notice of Privacy Practices for Mountain River Physical Therapy. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

Cancellation Policy

Appointment times are reserved exclusively for you. If you are unable to keep your appointment, we request 24 hours notice to allow us time to offer that appointment to someone else. We do understand that extenuating circumstances sometimes occur for missing appointments and should be discussed with the office manager.

Medicare Patients

You may not access Home Health Agency benefits and attend our clinics during the same period of time. You will be re-evaluated by your physical therapist every 10 visits. Due to Medicare requirements, we will contact your referring physician to provide a new referral to our office every 90 days as needed. If we do not receive a new referral from your physician as required, Medicare may deny payment of services and you could be financially responsible for therapy provided outside of the referral dates or we may be unable to continue treatment until a new referral is received. We will bill your secondary insurance if applicable. However, you are responsible for the deductible if it has not been met at the time of service, and the co-insurance if there is no secondary insurance. Are you currently receiving home health? ? ❑ Yes ❑ No _________

History

Prioritize your top 3 concerns you want to be sure we address in this evaluation and/or therapy:

1. ______________________________
2. ______________________________
3. ______________________________

Current Diagnosis: ______________________________

Family History

1. Lives with both parents: ❑Yes ❑No If no, describe: ______________________________
2. Siblings (name, ages, any history of delays):

____

____

____

Birth History

1. Is this child: ❑Biological Child ❑Adopted Child
2. Please indicate:
   - Length of Pregnancy: ____________________
   - Birth Weight: ____________________
   - Notable circumstances during pregnancy, labor, delivery, and/or following birth:
     ____
     ____
     ____

Medical History

1. Please mark any of the following illnesses that are common conditions in your child or which your child has required. List approximate ages in the space provided.

❑Allergies _________ ❑Asthma ________ ❑Ear Infections ________

❑Colds ________ ❑Croup ________ ❑Measles ________

❑Headaches ________ ❑High Fever ________ ❑Sinusitis ________

❑Pneumonia ________ ❑Seizures ________ ❑Other: ________

❑Tonsillitis/Adenoids ________ ❑Chicken Pox ________

2. Please indicate if your child has had the following vaccinations:

MMR: ❑Yes ❑No **Hepatitis:** ❑Yes ❑No **Chicken Pox:** ❑Yes ❑No

3. Has your child had a vision test/screening? ❑Yes ❑No Date:__________
   - Results: ____
4. List significant illnesses:
   ____
   ____
   ____
5. List specialists/physicians seen (including dates, names, specialty):
   ____
   ____
   ____

6. List any special tests (X-Rays, MRIs, etc.) including dates:
____
____
____

7. List any hospitalizations/surgeries including dates:
____
____
____

8. List any precautions you would like for us to know:
____
____
____

9. List any medications your child is taking and for what conditions:
____
____
____

Developmental History:

1. Please indicate at what age your child achieved the following developmental milestones:
    - Sitting: _________
    - Crawling: _________
    - Standing: _________
    - Walking: _________
    - Babbling: _________
    - Single Words: _________
    - Combining Words: _________
    - Toilet Training: _________
2. Describe general coordination:
____
____
____

3. Are there currently or have there been any feeding problems (i.e. sucking, swallowing, drooling, chewing, extreme picky eating, etc.)? Please explain:
____
____
____

4. Describe your child's current vocabulary:
____
____
____

5. How many words is he/she using? ❑100-1000+ ❑100's ❑50-100 ❑25-50 ❑10-25 ❑10 or less

   - If nonverbal, how does he/she communicate?

     ____

     ____

     ____

6. Describe social language abilities:

   ____

   ____

   ____

Educational History:

School: ________________ Grade: ________________

1. Please indicate your child's school schedule (i.e. days, times, etc.):

   ____

   ____

   ____

2. List your child's teacher and/or other educational contact person and phone number if appropriate:

   ____

   ____

3. Describe your child's school performance:

   ____

   ____

   ____

4. What, if any, special services does your child receive at school?

   ____

   ____

   ____

Previous Assessments and Therapies:

Please list any other evaluations**, including dates**, that your child has undergone or had pending (i.e. OT, PT, Speech and Language, Psychoeducational, etc.). List names and phone numbers.

OT: ____

PT: ____

SLT: ____

Other: ____

Please list any developmental therapies or interventions your child has participated in or is currently participating in (i.e. OT, PT, SLT, Music Therapy, counseling, etc.), including dates:

____
____
____
____

Social and Other Information:

Interests/Hobbies:

____
____
____
____

Describe peer relations:

____
____
____
____

Describe your child's most concerning/challenging behaviors:

____
____
____
____

My child's fears are:

____
____
____
____

What works to motivate or reward your child?

____
____
____
____

What other information would you like for us to know about your child that would aid in their evaluation/treatment?

____
____
____
____

Parental Consent

This consent serves as permission for treatment of my child by Mountain River Physical Therapy. I agree to pay for all services provided to my child.

____ _________________________

Parent/Guardian Date

____ _________________________

Witness Date

Consent for Treatment and Release of Information

I am aware of my diagnosis and wish to receive treatment from Mountain River Physical Therapy. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Mountain River Physical Therapy to release information, verbal and written, contained in my medical record and other related information to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize Mountain River Physical Therapy to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

Please tell us how you learned of our service or whom we can thank –

- ❑ I was a **Former Patient**
- ❑ **Family/Friend/Co-Worker** Recommendation
- ❑ MRPT **Brochure**
- ❑ **TV/Billboard** Advertisement
- ❑ Clinic **Sign**
- ❑ **Radio** Advertisement
- ❑ **Former Patient** Recommendation
- ❑ **Doctor** Recommendation
- ❑ Found you on the **Internet**
- ❑ **Publication/Newspaper** Advertisement
- ❑ Saw you at an **Event**
- ❑ Other ________________________________

I certify that I have read this agreement and my signature indicates my understanding and consent.

Signature: ____________________________________ Date: ______________________