



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 –

- | | |
|------------------------------------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> I was a Former Patient | <input type="checkbox"/> Former Patient Recommendation |
| <input type="checkbox"/> Family/Friend/Co-Worker Recommendation | <input type="checkbox"/> Doctor Recommendation |
| <input type="checkbox"/> MRPT Brochure | <input type="checkbox"/> Found you on the Internet |
| <input type="checkbox"/> TV/Billboard Advertisement | <input type="checkbox"/> Publication/Newspaper Advertisement |
| <input type="checkbox"/> Clinic Sign | <input type="checkbox"/> Saw you at an Event |
| <input type="checkbox"/> Radio Advertisement | <input type="checkbox"/> Other _____ |

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

Signature: _____

Date: _____