

**INTAKE QUESTIONS - Orthopedic**

DATE: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_

MOTHER'S AGE: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_

FATHER'S AGE: \_\_\_\_\_

If child does not live with parents, please indicate who they live with:

Child lives with:  Guardian(s)  Foster Parent(s)  Other \_\_\_\_\_

NAME: \_\_\_\_\_

NAME: \_\_\_\_\_

**FULL ADDRESS** where child resides: \_\_\_\_\_

City \_\_\_\_\_ ZIP \_\_\_\_\_

**FULL MAILING ADDRESS** if different from above: \_\_\_\_\_

City \_\_\_\_\_ ZIP \_\_\_\_\_

**PHONE NUMBERS (Please mark with numbers the order to call):**

HOME: \_\_\_\_\_

NAME/CELL: \_\_\_\_\_

NAME/CELL: \_\_\_\_\_

NAME/WORK: \_\_\_\_\_

NAME/WORK: \_\_\_\_\_

EMER. CONTACT NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_**DIAGNOSIS:** \_\_\_\_\_**PRECAUTIONS/CONTRAINDICATIONS:** \_\_\_\_\_

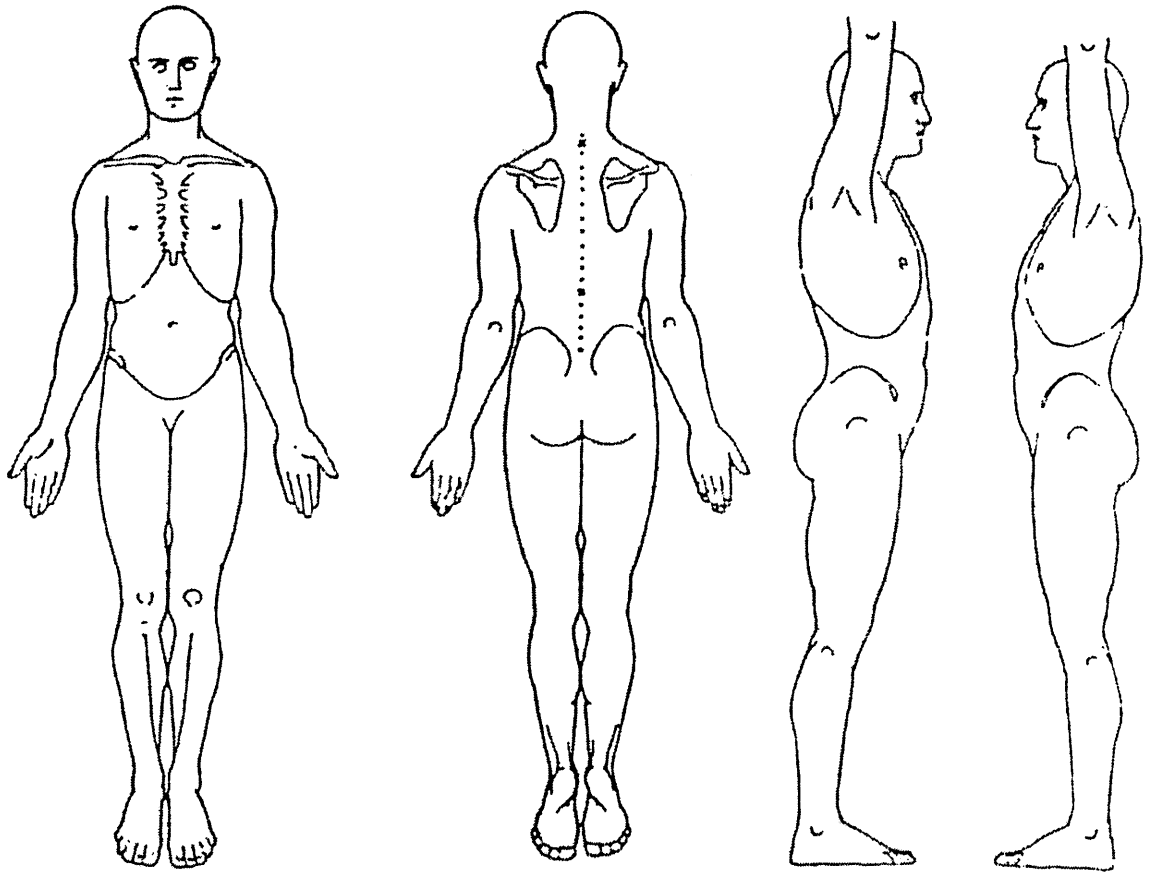
Please describe your concerns: \_\_\_\_\_  
\_\_\_\_\_

Date of Onset/Injury: \_\_\_\_\_

How did your child's injury occur? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

General Health:     Poor     Fair     Good     Excellent

Please mark below the areas of concern:



Child's Name: \_\_\_\_\_

Does your child have pain?  Yes  No

If yes:

What activities make the pain worse?

- Exercise (during)       Exercise (after)       Standing       Sitting  
 Walking       Sleeping       Other \_\_\_\_\_

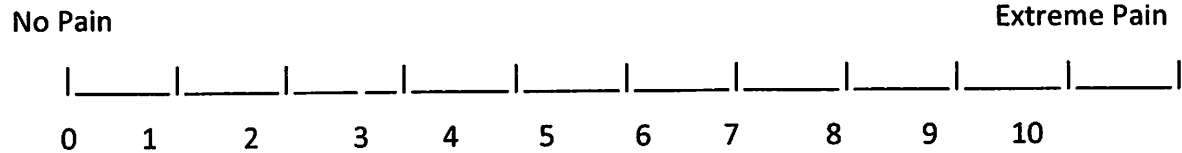
What reduces the pain?

- Lying Down       Sitting       Standing       Walking  
 Pain Medication       Ice       Heat       Other \_\_\_\_\_

Has your child ever had similar pain?      Yes       No

If yes, please describe: \_\_\_\_\_

Please have your child indicate their current level of pain:



Has your child reported pain or discomfort in any other areas? Yes       No

If yes, please describe: \_\_\_\_\_

Previous Physical Therapy/Occupational Therapy? Yes       No

When and Where: \_\_\_\_\_

**MEDICATIONS:**

- |                  |               |
|------------------|---------------|
| Medication _____ | Purpose _____ |
| Medication _____ | Purpose _____ |
| Medication _____ | Purpose _____ |
| Medication _____ | Purpose _____ |
| Medication _____ | Purpose _____ |

Child's Name: \_\_\_\_\_

**ALLERGIES:**

Testing \_\_\_\_\_ Results \_\_\_\_\_  
Testing \_\_\_\_\_ Results \_\_\_\_\_  
Testing \_\_\_\_\_ Results \_\_\_\_\_

**PROCEDURES/TESTS/X-RAYS/LABS/SURGERIES/ETC**

Please list all medical procedures, tests, x-rays, MRI's, surgeries and their dates

Procedure \_\_\_\_\_ Date \_\_\_\_\_ Results \_\_\_\_\_  
Procedure \_\_\_\_\_ Date \_\_\_\_\_ Results \_\_\_\_\_  
Procedure \_\_\_\_\_ Date \_\_\_\_\_ Results \_\_\_\_\_  
Procedure \_\_\_\_\_ Date \_\_\_\_\_ Results \_\_\_\_\_

Is there any additional information that would be helpful in understanding your child's problem?

\_\_\_\_\_

**SOCIAL HISTORY:**

Who lives in your home? (please include the names and ages of your child's siblings)

\_\_\_\_\_

Who is your child's primary caretaker? \_\_\_\_\_

Does your child attend school? \_\_\_\_\_ What grade? \_\_\_\_\_

What languages are spoken in your home? \_\_\_\_\_

Is your child involved in recreational and/or sporting activities? Yes  No

Please list: \_\_\_\_\_

Frequency of Activity  Daily  Weekly  Every other week  Monthly

How would your child rate their level of activity?

	<u>Prior to Injury</u>	<u>Currently</u>
Much less than other children their age	<input type="checkbox"/>	<input type="checkbox"/>
Less than other children their age	<input type="checkbox"/>	<input type="checkbox"/>
The same as other children their age	<input type="checkbox"/>	<input type="checkbox"/>
More than other children their age	<input type="checkbox"/>	<input type="checkbox"/>
Much more than other children their age	<input type="checkbox"/>	<input type="checkbox"/>

Child's Name: \_\_\_\_\_

**OTHER SERVICES:**

Please list any other professionals and agencies who are currently seeing or have seen your child.

Primary Physician: \_\_\_\_\_

Orthopedic Surgeon: \_\_\_\_\_

Other Specialist Physicians: \_\_\_\_\_

Nutritionist/Dietician: \_\_\_\_\_

Other: \_\_\_\_\_

**GOALS for THERAPY:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_



## Patient Authorization Form

<b>Patient Name:</b>	<b>Date of Birth:</b>
<b>Release of Information and Consent to Treat</b>	
<p>I am aware of my child's diagnosis and wish to receive treatment at Center for Pediatric 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.</p> <p>I give permission to Center for Pediatric Therapy and affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment or payment for services provided.</p> <p style="text-align: right;">Initial: _____</p>	
<b>Assignment of Benefits</b>	
<p>I authorize payment directly to Center for Pediatric Therapy for services. This is a direct assignment of rights and benefits. A photocopy of this assignment shall be considered as effective and valid as the original.</p> <p style="text-align: right;">Initial: _____</p>	
<b>Notice of Privacy Practices (HIPAA Acknowledgement and Consent)</b>	
<p>I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Center for Pediatric Therapy. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and healthcare operations.</p> <p style="text-align: right;">Initial: _____</p>	
<b>Payment Guarantee</b>	
<p>I agree to pay Center for Pediatric Therapy for the services provided to my child. If any law, such as workers' 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 payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.</p> <p><b>The Benefit Verification for is only an explanation of coverage as quoted by my insurance company and it is not a guarantee of coverage or payment. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment and services.</b></p> <p>I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Center for Pediatric Therapy.</p> <p style="text-align: right;">Initial: _____</p>	
<b>Parent/Guardian Signature:</b>	<b>Date:</b>



**Insurance/Guarantor Information**

\_\_\_\_\_  
(PATIENT NAME)

\_\_\_\_\_  
(DOB)

INSURANCE INFORMATION

Primary Insurance Company and Phone# \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Guarantor: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
(or responsible parent)

Employer Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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Secondary Insurance Company and Phone# \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Guarantor: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
(or responsible parent)

Employer Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Other information:



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## PRIVATE AND STATE INSURANCE COVERAGE CHANGES

If you have changes in insurance, we need to be notified in advance so that we can determine coverage and need for prior authorization.

Initial: \_\_\_\_\_

If your child is covered, partially or in full, by state insurance, it is your responsibility to provide us with any new coverage information by the first visit of each month when any changes occur. **Because it is the insurance that you carry for your child and it renews on a monthly basis, we require that you bring in the updated insurance information by the first visit of the new month if it has changed.** Otherwise, we will be unable to see you for that visit.

Initial: \_\_\_\_\_

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For many public assistance programs and private insurances, we are required to obtain authorization prior to the patient's appointment. **Without current insurance information (i.e. current/new ID card, etc), we are unable to do so and your child's treatment may be affected.**

We welcome any updated information to be faxed to us at (509) 487-3025. Please call with any questions or concerns.

**By signing below, I acknowledge that I have read the above policy and understand it.**

PATIENT'S NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

PRINT NAME \_\_\_\_\_





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## CANCELLATION/NO SHOW/TARDINESS POLICY

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Dear Parents/Guardians,

Thank you for choosing Center for Pediatric Therapy for your child's care. The policies written below are designed to improve our ability to see all of our patients and to provide complete and consistent treatment for your child. We hope that these policies will improve our overall service to our patients. Since continuity of care is important to maximize the outcomes of your child's therapy, we use the following guidelines for your appointments:

1. Therapists often are not able to wait more than 15 minutes for a late appointment. **Please notify your therapist or the front office as soon as you know you will be late.** Because of scheduling constraints, late arrivals may not be able to be seen, and if seen, the session will end at the regularly scheduled time.
2. If you need to cancel your child's appointment, our clinic requires that you **cancel 24 hours in advance**, except in emergency or illness situations.
3. If you have **three consecutive cancellations** of your child's appointments or you **miss more than ½ of your scheduled appointments**, you **may lose your standing appointment** time slot. Additionally, your child **may be placed on hold** for therapy. You and your child's primary care physician will be notified by phone or letter of such circumstances.
4. If your child does not attend their scheduled appointment and you have not called to give notification that the session would be missed, you will be considered a "No Show". If you have **two No Shows** for scheduled appointments, your child **will be discharged from all current therapy services** and you and your child's primary care physician will be notified.

Please feel free to speak with your therapist about any concerns you may have about these policies, or to discuss your regularly scheduled appointment time if you know that your current scheduled time is not optimal. We will do everything possible to provide you with a time that is consistently available for both you and your therapist. Thank you for your cooperation.

**By signing below, I acknowledge that I have read the above policy and understand it.**

PATIENT'S NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

## WELLNESS POLICY

The health and wellness of your child and our staff is very important to us. Because of this, we have developed a health care plan to assist in ensuring that we all can help take care of each other by taking care of health concerns.

We will not be able to have your child receive therapy for the day until the following symptoms are gone for at least 24 hours:

- Fever (100 degrees or higher)
- Nasal or ear discharge that is other than clear (i.e. yellow, green or thick consistency)
- Severe/continual cough
- Severe sore throat or strep throat
- Severe earache
- Vomiting or diarrhea (3 or more times in a 24-hour period)
- Pink eye
- Lice
- Unknown or contagious rash
- Any other contagious illness
- Any communicable disease

We will begin therapy earlier only if accompanied by a doctor's note releasing your child back to therapy as no longer being contagious. If your child becomes ill while in therapy, he/she will need to be taken home.

These precautions are taken for the health and safety of your child, other children and the staff at Center for Pediatric Therapy. If your child is exposed to a contagious illness, please inform the staff as soon as possible so we will be able to alert families and staff that may have also been exposed. We will post a notice informing other parents of the contagious disease and keep your child's identity anonymous.

**By signing below, I acknowledge that I have read the above policy and understand it.**

PATIENT'S NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

## PHOTO RELEASE FORM

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_,

\_\_\_ do

\_\_\_ do not

grant permission to Center for Pediatric Therapy, LLC and its agents or employees to use photographs and/or video of me and/or my child for use in promotional and educational materials such as brochures, websites, home exercise programs, and advertisements. In giving my consent, I hereby release and hold harmless, Center for Pediatric Therapy, LLC, their employees, agents and designees from any and all responsibility or liability. I understand that I will receive no compensation, should any photographs of my child be used.

\_\_\_\_\_  
Printed name of parent or legal guardian

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date



## **NO SHOES POLICY**

**(but socks are required)**



~ No Shoes ~



We have a No Shoes in the treatment areas policy. This is to reduce the amount of dirt for our small children who are crawling on the floors still.

Socks are required. If you did not bring socks, we have socks available for you to use while you are here. We request that you return the socks. We also request that you bring your own socks for future appointments.

You may see some children wearing shoes. We allow some of the children who wear braces for their feet to wear their shoes as the shoes provide the stability to the braces for them to walk.

You may see some of the therapists wearing shoes. Because we are here all day long, some of the therapists have chosen to bring new shoes/never worn outside shoes to wear during therapy for their own comfort and support.

If you have any questions, please feel free to ask.

Thank you