FYZICAL Therapy & Balance Centers

Account #: _____

PEDIATRIC THERAPY REGISTRATION

Date: _____

Patient Name: _____ DOB: ____ / ____ / _____ Age: ___
Last First MI Mo Day Yr

Address: _____ City: _____ State: _____ Zip: _____

Contact Phone: (____) ____-_____ Insured Social Security Number: _____ - _____ - _____

Parent/Guardian Name(s) and Phone #s:

Name: _____ Phone: (__) ____-_____ Alternate: (__) ____-_____ ☐ Parent ☐ Guardian

Name: _____ Phone: (__) ____-_____ Alternate: (__) ____-_____ ☐ Parent ☐ Guardian

Are parents: ☐ Married ☐ Separated ☐ Divorced ☐ Other

E-Mail Address: _____

Emergency Contact: _____ Phone: (____) ____-_____

Relationship to patient: _____

Referring Physician: _____ Phone: (____) ____-_____

Primary Care Physician: _____ Phone: (____) ____-_____

Phone Number(s) to receive text message for appointment reminders:

Primary Phone #: (____) ____-_____ Alternate Phone #: (____) ____-_____

Has your child been seen at one of our clinics before? Yes ☐ No ☐

If Yes, which location(s) and for what services? _____

How did you hear about our clinic?

Returning Patient ☐ Family/Friend ☐ Web-Site ☐ Newspaper Ad ☐

Physician Recommend ☐ Facebook ☐ TV Ad ☐ Mailing ☐

Birth History:

Were there any problems/complications during pregnancy and/or birth? Yes ☐ No ☐

If Yes, briefly describe: _____

_____

Was the child born pre-term? Yes ☐ # weeks: _____ No ☐

Were there any health problems or medications in the first 2 weeks of life? Yes ☐ No ☐

If Yes, briefly describe: _____

_____

For Office Use

Onset Date _____ Body Region _____

Referral Date _____ Diagnosis _____

Account #: _____

Home Environment & Family History:

Who lives at home with the child? *(siblings & ages, mother, father, step-parents, grandparents, pets, etc.)*

_____

_____

Have any family members had any speech, language, hearing problems, behavioral, mental health or learning difficulties?

☐ No ☐ Yes Describe: _____

What is the primary language used with this child? _____

Other language(s) used in the home? _____

Is/was this child adopted (or in foster care)? ☐ Yes ☐ No

If Yes, at what age? _____ From Where? _____

Any cultural or religious considerations for therapy? *(holiday celebrations, prohibitions, etc.)*

_____

Past Medical History:

Does your child have history of any of the following?

☐ Seizures	☐ Asthma	☐ Thyroid	☐ Respiratory infection
☐ Cardiac	☐ Reflux	☐ Ear Infection	☐ Head Injury
☐ Cancer	☐ Tonsils/Adenoids	☐ Kidney Stones	☐ Ear Tubes

☐ Trauma: _____

☐ Other: _____

Please provide further explanation(s) for any items checked above:

_____

_____

Has your child been diagnosed with any Developmental or Sensory Disorders?

☐ ADHD	☐ Anxiety	☐ Autism	☐ Articulation Disorder
☐ Blind/Visually Impaired	☐ Cerebral Palsy	☐ Deaf/Hard of Hearing	☐ Degenerative Condition
☐ Dyslexia	☐ Down`s Syndrome	☐ Fragile X Syndrome	☐ Intellectual Disability
☐ Language Disorder	☐ Learning Disorder	☐ Opposition Defiance Disorder	☐ Sensory Processing Disorder
☐ Social Communication	☐ Stuttering	☐ Fine Motor Delay	☐ Gross Motor Delay

☐ Other: _____

Please provide further explanation(s) for any items checked above:

_____

_____

Medications *(list all medications, dosages and/or supplements):*

_____

_____

Allergies *(list all drug allergies, food allergies/restrictions, environmental allergies, etc.)*

_____

_____

Is the child allergic to latex? ☐ Yes ☐ No

Account #: _____

Medical Tests & Evaluations:

Has your child had any previous:

☐ ABA/Behavioral ☐ Cardiac/ECG ☐ CT-Scan ☐ Echocardiogram/Ultrasound
☐ Hearing ☐ MRI ☐ Orthopedic ☐ Psychological/Neuropsychological
☐ Swallow ☐ Vision ☐ X-Rays
☐ Other: _____

Please provide further explanation(s)/result(s) for any items checked above:

_____

_____

Medical Precautions:

Please list any medical precautions OR ☐ N/A

_____

_____

Vision/Hearing History:

Please list any visual or hearing problems OR ☐ N/A

_____

_____

Equipment/Devices:

Does your child use any of the following?

☐ Walker ☐ Crutches ☐ Loft-Strand Crutches ☐ Wheelchair ☐ Braces (Type) _____
☐ Communication Device (Type) _____ ☐ Other: _____

Therapy History:

Has your child had any previous:

☐ ABA/Behavioral Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy
☐ Other: _____

If so, when? _____ Where? _____ For how long? _____

Outcomes: _____

Education & Schooling:

How is your child currently educated? ☐ Pre-School/School ☐ Distance Learning ☐ Caregiver-led at home

Current School: _____ Grade: _____

Is child currently receiving services in school? ☐ Yes ☐ No If yes, what service(s)? _____

Does your child have an IEP or IFSP? ☐ Yes ☐ No

Does your child have a 504 plan? ☐ Yes ☐ No

List any academic or learning concerns: _____

Behavioral Characteristics, Social Interaction & Play Skills:

☐ Needs to be in control ☐ Stubborn ☐ Destructive/Aggressive
☐ Easily Frustrated ☐ Short Attention Span ☐ Separation Difficulties
☐ Difficult to Discipline ☐ Poor Eye Contact ☐ Easily Distracted
☐ Frequent Tantrums ☐ Cooperative ☐ Willing to try new activities
☐ Engages in Conversation ☐ Makes Friends Easily ☐ Plays Well with Others

Account #: _____

PHYSICAL THERAPY *Please fill out the following section if your child is being seen for Physical Therapy*

Gross Motor Skills:

Check the milestones your child HAS met *independently*:

☐ Roll ☐ Sit Alone ☐ Crawl ☐ Pull to Stand ☐ Stand Alone
☐ Walk ☐ Climb Stairs ☐ Run ☐ Ride Bike ☐ Skip/Gallop
☐ Jump ☐ Throw Ball ☐ Catch Ball

Check if appropriate:

☐ Trips often ☐ Clumsy ☐ Afraid of heights/climbing ☐ Avoids uneven surfaces

What goals do you wish to accomplish for your child with Physical Therapy?

_____

_____

OCCUPATIONAL THERAPY *Please fill out the following section if your child is being seen for Occupational Therapy*

Dominant Hand Preference: ☐ Left ☐ Right ☐ Both

Fine Motor Skills:

Check the milestones your child HAS met *independently*:

☐ Eat with Fingers ☐ Use Utensils ☐ Drink from Cup ☐ Scribble/Draw ☐ Use a Straw
☐ Brush Teeth ☐ Cut with Scissors ☐ Use Toilet ☐ Stack Blocks ☐ Tie Shoes
☐ Wash/Bathe ☐ Dress/Undress ☐ Button/Zip

Daily Routines:

Please comment on your child`s habits, challenges, assist level, or your concerns for each item:

Sleep: (bedtime routine, average hours slept, name time/length, difficulties falling/staying asleep, difficulties waking)

_____

_____

Dressing: (dress/undress self, selective, aversions)

_____

_____

Toileting: (trained day/night)

_____

_____

Eating: (avoids/dislikes certain foods, strong food preferences, variety of foods/textures)

_____

_____

Bathing/Oral Care: (independence, aversion)

_____

_____

What goals do you wish to accomplish for your child with Occupational Therapy?

_____

_____

Account #: _____

FEEDING THERAPY *Please fill out the following section if your child is being seen for Feeding Therapy*

Does your child have any of the following problems?

☐ Vomiting ☐ Teeth Grinding ☐ Gagging ☐ Coughing ☐ Profuse sweating (diaphoresis)

☐ Food selectivity by type (eating narrow variety of foods) ☐ Food refusal (refusing all or most foods)

☐ Food selectivity by texture (textures are not age appropriate) ☐ Dysphagia (problems swallowing)

☐ Oral motor delays (problems with chewing, lip closure, sucking) ☐ Strong food preferences

☐ Abnormal preferences (refuses food if not certain temperature, has to have certain cup/utensil)

☐ Other: _____

Has your child been seen or have recommendations from:

☐ Dietitian: *Please list* _____

☐ Gastroenterologist: *Please list* _____

Please indicate the approximate age if/when the child stopped:

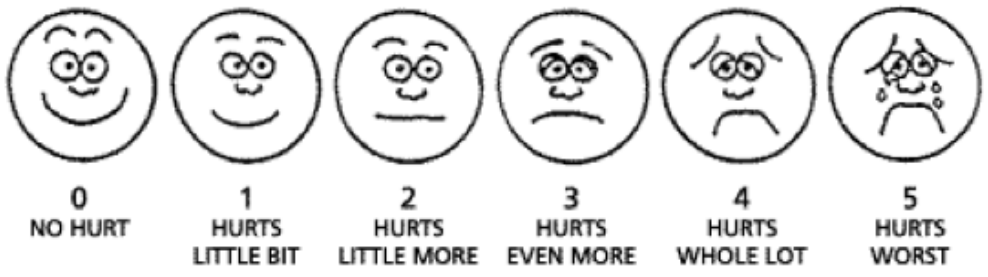
Activity	**Age stopped**
Using pacifiers?	
Using bottles?	
Thumb sucking?	
Nursing?	

Pain Assessment:

Does the child appear in or complain of pain when eating? ☐ Yes ☐ No

If so, how does the child display signs of discomfort? _____

Can the child express his/her own pain or discomfort using the faces below? If so, mark one:



0 1 2 3 4 5

What goals do you wish to accomplish for your child with Feeding Therapy?

_____

_____

Account #: _____

SPEECH THERAPY *Please fill out the following section if your child is being seen for Speech Therapy*

Developmental History:

Check the milestones your child HAS met:

☐ Babbled ☐ Said first word ☐ Put 2-3 words together ☐ Put sentences together ☐ Engage in conversation

Communication:

Can your child clearly and appropriately communicate the following?

☐ Statements ☐ Questions ☐ Answers ☐ Wants ☐ Needs (help) ☐ Feelings

☐ Discomfort ☐ Denial/Protests ☐ Follow simple commands ☐ Follow complex commands

How does your child usually communicate?

☐ Gestures ☐ Crying ☐ Leading ☐ Single Words ☐ Short Phrases ☐ Sentences

Is the child's voice hoarse or husky? ☐ Yes ☐ No

Does your child stutter? ☐ Yes ☐ No Describe: _____

About how much of what your child says can you understand? ☐ Almost All ☐ Most ☐ Half ☐ Quarter or less

About how much could a stranger understand? ☐ Almost All ☐ Most ☐ Half ☐ Quarter or less

What goals do you wish to accomplish for your child with Speech Therapy?

_____

_____

YOUR THOUGHTS

Are there other concerns you have about your child not listed/discussed?

_____

_____

Are there other things about your child that would help us serve them during therapy?

_____

_____

Patient Name:_____ Account#:_____

Acknowledgement of Family Welcome Booklet & Policies/Procedures

I have received and read the Family Welcome Booklet and certify that I understand, agree and accept all outlined comments, policies and procedures. Furthermore, I certify I am the parent, guardian, caregiver or duly authorized as the patient's agent or representative to execute the policies/procedures outlined in the booklet.

_____ _____ _____

Signature Printed Name Date

Consent For Treatment

I hereby give consent to Capitol Physical Therapy Associates, Inc. (DBA FYZICAL Therapy Mid-Michigan) and its designated agents to provide evaluative and treatment services as necessary and reasonable for my child's care.

_____ _____ _____

Signature Printed Name Date

Authorization to Release Medical Information for Insurance

I hereby authorize Capitol Area Physical Therapy Associates, Inc. (DBA FYZICAL Therapy Mid-Michigan) to release any information necessary to process claims.

_____ _____ _____

Signature Printed Name Date

Authorization to Release Medical Information to Family/Non-Family Members

I understand that my child's medical information is confidential and cannot be released without my authorization. I also understand that I may not always be able to bring my child to his/her therapy session(s). I authorize the following individuals to bring my child for their therapy treatments and give permission to the following individuals to obtain applicable information from Capitol Area Physical Therapy Associates, Inc. (DBA FYZICAL Mid-Michigan) regarding my child's therapy, both verbal and written and can sign for consent if medically necessary:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Billing Policy

I have received, read and understand the financial/billing policy as outlined in the Family Welcome Booklet. I agree to accept responsibility for any balance on my account that is not payable by my insurance company. I agree to pay for any/all copays and/or deductibles at the time of service(s) and authorize Capitol Area Physical Therapy Associates, Inc. to charge my credit or debit card on file (see form) if/when I or the responsible party is not present on the date services are rendered. Lastly, I give Capitol Area Physical Therapy Associates, Inc. permission to bill my insurance company on my behalf.

_____ _____ _____

Signature Printed Name Date

Acknowledgement of Cancellation/No-Show Policy

I have received, read and understand the cancellation and no-show policy as outlined in the Family Welcome Booklet.

_____ _____ _____

Signature Printed Name Date

Patient Name:_____ Account#:_____

Credit/Debit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled and/or therapy services have ended.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Other _____
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):
Cardholder ZIP Code (from credit card billing address):
☐ Copay $_____ ☐ Coinsurance $_____ ☐ Deductible $_____ ☐ Other:_____

I, _____, authorize Capitol Area Physical Therapy Associates, Inc. (DBA FYZICAL Mid-Michigan) to charge the above card for agreed upon balances. I understand I may not always be present on the date(s) of service(s) my child attends therapy, but recognize that payment is due at the time service(s) is/are rendered. I understand the amount(s) are an estimation and I accept responsibility for any remaining balance on my account that is not payable by my insurance company. I understand that my information will be saved on file for future transactions on my child's account.*

_____ _____ _____

Signature Printed Name Date

*Please refer to our full billing/financial policy for complete details

Patient Name:_____ Account#:_____

Authorization Form to Use/Disclose Protected Health Information (PHI)

**Please Print

Patient Name:_____ DOB:_____

☐ I'm authorizing the person(s)/organization(s) listed below to receive or acquire Protected Health Information from Capitol Area Physical Therapy Associates, Inc. (DBA FYZICAL Therapy and Balance Centers).

List below the person or name of the organization you are authorizing to make the requested uses or disclosures. Please include the recipient's name, phone and email address.

Name/Agency:_____ Phone:_____ Email:_____

Name/Agency:_____ Phone:_____ Email:_____

Name/Agency:_____ Phone:_____ Email:_____

Please specify the records you wish to have. Check all that apply.

☐ Therapy Evaluation
☐ Progress Notes
☐ Prescriptions/Plans of Care
☐ Daily Treatment Records
☐ Exercise Flow Sheets
☐ Discharge Notes
☐ Billing Records

Other Instructions/Comments:

_____

_____

_____

Starting date and ending date of your request: From:_____ To:_____

Signature:_____ Date:_____

Are you the patient listed above? ☐ Yes ☐ No

If no, please describe your authority to act as the patient's representative:_____

_____

Your signature above affirms you have read and agree to the following: You have the right to revoke authorizations not prohibited In the Privacy Notice. In order to do so you must submit your request in writing. This authorization cannot be combined with any other authorization except for authorizations conditioned on the provision of treatment. Your authorization allows Capitol Area Physical Therapy Associates, Inc. and staff to use or disclose protected health information you have described. If this disclosure includes copying of the patient chart, the entire contents of the medical record will be disclosed, including records from other entities unless specifically restricted by the requester or by law. You may be charged copying fees as outlined by theMedical Records Access Fee Schedule. Your authorization includes transmission of the medical records by faxunless you specify otherwise in the description space.

Patient Name:_____ Account#:_____

Photography Consent for Minors for Marketing

I hereby grant permission to Capitol Area Physical Therapy Associates, Inc. (DBA FYZICAL Therapy and Balance Centers) to take and use photographs, video and/or digital images of (child's name)_____ _____ for use in/on websites, social media accounts, or other electronic communications, news releases and/or educational materials.

I authorize the use of these images without compensation to me. All negatives, prints, video and digital reproductions shall be property of Capitol Area Physical Therapy Associates, Inc. (DBA FYZICAL Therapy and Balance Centers).

_____	_____	_____
Signature	Printed Name	Date