FAMILY Physical Therapy & SPORTS CENTER

Tree Top Therapy
Pediatric Therapy Services

PATIENT INFORMATION
(PRINT CLEAR AND COMPLETE)

PATIENT NAME: _____
FIRST MIDDLE LAST
DATE OF BIRTH: _____ SSN: _____
HOME ADDRESS: _____
STREET CITY STATE ZIP CODE
***If mailing address is the same leave blank.**
MAILING ADDRESS: _____
STREET CITY STATE ZIP CODE
HOME PHONE: _____ PRIMARY PHONE ___

MOM'S NAME: _____ CELL PHONE: _____ ___

DAD'S NAME: _____ CELL PHONE: _____ ___
EMAIL ADDRESS: _____
Do you want emailed appointment reminders? Y_____ N_____

Referring Physicians: _____

IN CASE OF EMERGENCY PLEASE CONTACT: _____
RELATIONSHIP TO PATIENT: _____ PHONE: _____

PERSON FINACIANLLY RESPONSIBLE: _____
ADDRESS: _____ CITY: _____ ZIP: _____
SSN: _____ DOB: _____

POLICY HOLDER: _____ DOB: _____
INSURANCE COMPANY: _____
POLICY NUMBER: _____ GROUP NUMBER: _____

MOTOR VEHICLE: Y____ N____ DATE OF INJURY: _____
AT FAULT: ____ NOT AT FAULT: ____ CLAIM NUMBER: _____
LIABILITY INSURANCE COMPANY: _____
ADJUSTER NAME: _____ PHONE: _____

PARENT/GUARDIAN: _____ DATE: _____

Pediatric

The purpose of this questionnaire is to help us understand and keep accurate records of your health status. Please complete form and your therapist will answer any questions during you evaluation. This form is considered part of your medical record.

Name: _____ Date of Birth/Age: _____

Has your child had surgery for this injury? YES / NO **Date and Type of Surgery**: _____

Is your child in pain/or shown signs of pain? (please circle) YES / NO

My Pain can be described as: (Circle all that apply)

Constant Intermittent Sharp Dull Aching Stabbing Numbness Pins/Needles

Is your child taking medications? (Please Circle) YES / NO

Please List: _____

Have you had any of the following medical or rehabilitative care for this injury/episode?

	YES	NO		YES	NO
General Practitioner	___	___	CT Scan	___	___
Chiropractor	___	___	EMG/NCV	___	___
Occupational Therapy	___	___	MRI	___	___
Physical Therapy	___	___	Myelogram	___	___
Massage Therapy	___	___	X-Rays	___	___
Neurologist	___	___	Emergency Room	___	___
Orthopedist	___	___	Podiatrist	___	___

Do you now have, or have you ever had any of the following?

	YES	NO		YES	NO
Asthma, bronchitis, or Emphysema	___	___	Severe or Frequent Headaches	___	___
Shortness of Breath/Chest Pain	___	___	Vision or Hearing Difficulty	___	___
Coronary Heart Disease or Angina	___	___	Numbness or Tingling	___	___
Do you have a Pacemaker?	___	___	Dizziness or Fainting	___	___
High Blood Pressure	___	___	Weakness	___	___
Heart Attack/Heart Surgery	___	___	Weight loss/Energy Loss	___	___
Blood Clot/Emboli	___	___	Hernia	___	___
Stoke/TIA	___	___	Epilepsy/Seizure	___	___
Allergies	___	___	Thyroid Trouble/Goiter	___	___
Pins/ Metal Implants	___	___	Any Other Neurological Disease	___	___
Joint Replacement (any joint)	___	___	Bowel or Bladder Problems	___	___
Diabetes	___	___	Neck Injury/Surgery	___	___
Infectious Diseases	___	___	Shoulder Injury/Surgery	___	___
Cancer/Chemotherapy/Radiation	___	___	Elbow/Hand Injury/Surgery	___	___
Arthritis/Swollen Joints	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Sleeping Problems/Difficulty	___	___	Leg/Ankle/Foot Injury/ Surgery	___	___
Do You Smoke?	___	___	Any Other Neurological Disease	___	___
Latex Sensitivity/Allergy	___	___	History of ear infections	___	___
Speech Difficulty/Concern	___	___	Behavior Issues	___	___

Patient/ Guardian Signature: _____ Date: _____

Physical Therapist Initials: _____ Date: _____

Notice of Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE PREVIEW IT CAREFULLY.

Family Physical Therapy and Sports Center, P.C. is required by federal law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information. This notice fulfills the "Notice" requirements of the Health Information Portability and Accountability Act of 1996 (HIPAA) Final Privacy Rule. If you have questions about any part of this Notice of Information Privacy practices or desire to have further information concerning information practices at Family Physical Therapy and Sports Center, P.C., please call us at (308) 455-1781.

Acknowledgement of receipt of this notice: I have been informed of the Privacy Policies of Family Physical Therapy and Sports Center, P.C.

_____ Date:_____

Signature of Recipient

☐ Individual

☐ Personal Representative

Release of Personal Health Information:
If you wish anyone other than yourself to have access to your medical records or financial records, please list those names below and state their relationship to you. Thank you.

Release to: _____ Relationship: _____

_____ _____

_____ _____

_____ _____

FAMILY PHYSICAL THERAPY & SPORTS CENTER TREE TOP THERAPY

MARKETING CONSENT AND RELEASE FORM

_____

1. I, _____ (print name) hereby grant the Family PT, its agents and assigns Family PT the perpetual and irrevocable right to use the name, address, picture, image, likeness, or voice of myself and the minor individuals named below, in any form of media or advertising, now known or hereafter devised, promoting Family PT or any person or entity placing any advertising in any publication printed/ run or distributed by Family PT.

2. In the event I, or a person on my behalf, provide Family PT with a photograph or recording of me or any person named above, I hereby represent that I have obtained any approvals required for Family PT to exercise any of the rights stated herein.

3. I acknowledge and agree that neither I, nor any person named above, have any right of review, approval, or compensation, and Family PT is forever released from any claim (including, without limitation, claims based upon any invasion of privacy or right of publicly) arising out of any use of the name, address, picture, image, likeness, or recording of me or any person named above.

I AM AT LEAST 19 YEARS OLD AND AGREE TO THE ABOVE TERMS:

_____ _____

Signature Address City/State/Zip Code

_____ _____ _____

Print Name Date Telephone Number

FOR ANY MINOR UNDER THE AGE OF 19 YEARS, PLEASE COMPLETE THE FOLLOWING:

I, the undersigned, hereby represent and warrant that I am at least 19 years old and I am the Parent and/or Guardian of _____, (name of minor)- a minor, and have full authority to legally authorize on behalf of any such minor the above consent and Release which I have read and approved. I hereby release and agree to hold Family PT harmless from any claim, liability, damage or expense related to any exercise by Family PT of the rights granted by the above Consent and Release.

_____ _____

Signature of Parent/Guardian Address City/State/Zip Code

_____ _____ _____

Print Name Date Telephone Number

THIS AREA FOR FAMILY PT REFERENCE ONLY:

PATIENT NAME: _____

FAMILY Physical Therapy & SPORTS CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION AND CONSENT TO TREAT

The undersigned hereby authorizes ***FAMILY PHYSICAL THERAPY AND SPORTS CENTER*** to furnish from my medical record requested information or excerpts to the referring physicians, if any, and to Medicare, Medicaid, or any insurance company for the purpose of processing claims and to obtain payment of the account for services provided to the patient. By signing, this authorization the patient, parent or legal guardian of the patient hereby gives to medical treatment.

MEDICARE RELEASE

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any authorized benefits be made on my behalf.

FINANCIAL AGREEMENT

The undersigned hereby agrees that, in consideration of the services to be rendered to the patient, to pay ***FAMILY PHYSICAL THERAPY AND SPORTS CENTER*** in accordance with the regular rate and the offices payment policy. Some insurance companies do not pay for hot/cold packs. These are billable services and due by the patient. **A LATE FEE WILL BE CHARGED TO ALL OVERDUE ACCOUNT BALANCES AFTER 60 DAYS.**

WORKER'S COMPENSATION

PLEASE NOTIFY OFFICE STAFF AT CHECK-IN IF THIS IS A WORKER'S COMPENSATION INJURY

Any patient claiming worker's compensation must bring notice of injury from their employer before it will be turned into worker's compensation insurance. Otherwise, all billing will be submitted to personal medical insurance.

ATTENDANCE POLICY

If you are more than 15 minutes late for your appointment and fail to notify us, treatment may be cancelled. Please give 24 HOUR notice if you need to cancel your appointment. **Three consecutive no-shows** will result in the cancellation of all remaining scheduled appointments. Repeated failure to comply with this **ATTENDANCE POLICY** will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

This undersigned certifies that he/she has read the forgoing, and is the patient or duly authorized by or on behalf of the patient to execute the above and accepts its terms.

Patient or Parent/Legal Guardian Signature _____ **Date** _____