NEW PATIENT INFORMATION

Pediatric Therapy Center

PLEASE PRINT

Today's Date: _____ 1st Therapy Visit OT / PT / ST Therapist Seen: _____

Child: _____ Date of Birth: _____ Age: _____ Sex: ☐ M or ☐ F
Last Name First M.I. Month/Day/Year

_____ ( ) _____
Street Address City State Zip Code Area Code Phone #

Mother's Name: _____ Date of Birth: _____
Last Name First M.I. Month/Day/Year

Mom Cell: ( ) _____ Mom E-Mail: _____

Father's Name: _____ Date of Birth: _____
Last Name First M.I. Month/Day/Year

Dad Cell: ( ) _____ Dad E-Mail: _____

_____
Street Address (if different from above) City State Zip Code

Diagnosis per Physicians Referral: _____

_____ ( ) _____
Area Code Phone #

Pediatrician:

EMERGENCY MEDICAL RELEASE

In the event medical attention is required for your child while on the premises of Pediatric Therapy Center, it will be necessary to have your authorization and contact information.

Alternate: _____ Phone: _____

As legal guardian of the above named child, I give my permission to furnish emergency medical services for minor injuries received while in a therapy session. In the event the emergency is life threatening, I give my permission to contact emergency personnel on the behalf of my child.

_____ Date: _____
Parent/Legal Guardian Signature

CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I hereby authorize Pediatric Therapy Center to:

1. Release any necessary information acquired in the course of my examination or treatment to my referring physician, health plan/insurance representative or attorney.

2. To initiate a complaint on my health to The Chief Insurance Commissioner and the internal Review Processing Board of my insurance carrier for untimely processing of insuring claims.

3. Assign all benefits for which I am entitled by my insurance carrier to Pediatric Therapy Center and understand that I am financially responsible for all charges whether or not paid by my insurance.

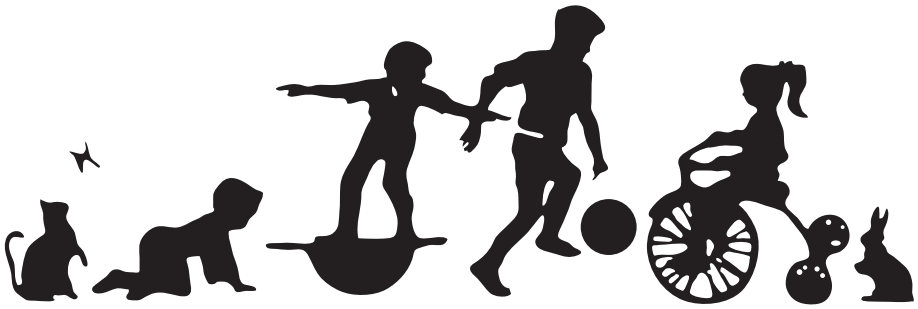
I hereby authorize Pediatric Therapy Center to provide appropriate evaluation and treatment as needed

Signature: _____ Date: _____
(Parent/Legal Guardian Signature)

I have seen the attached HIPPA Notice of Privacy Practice. Initials _____

HIPPA Communication Consent Initials (emails) _____ Initials (text) _____

I understand that any information may not be secure and I will not hold PTC or any one of the workforce members liable for loss of any associated information transmitted by the above consented forms.



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24- HOUR CANCELLATION POLICY/ NO SHOW

Pediatric Therapy Center values your child as a patient in our practice. In order for your child to receive the best results from treatment, it is important that they attend therapy consistently. Effective **Immediately**, Pediatric Therapy Center will be implementing a $50 fee for a No Show or any appointment cancelled **within less than 24 hours**.

Pediatric Therapy Center has a waiting list of patients who are ready to start therapy.

If we know ahead of time that you will not be able to make an appointment, we can schedule another patient in that time slot.

This $50 fee will be collected at your next visit.

Thank you for understanding,

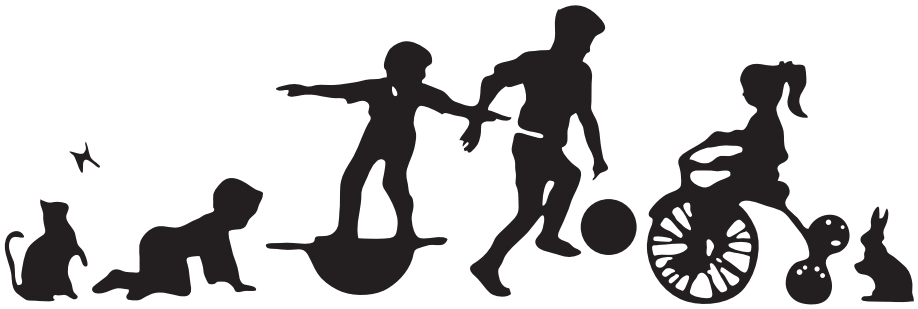
Pediatric Therapy Center

_____

Print Child's Name

_____ _____

Legal Guardian Signature Date



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☐ RECURRING WEEKLY PAYMENT - OFFICE STAFF

I, _____ the parent/legal guardian of

_____ give my consent for Pediatric Therapy Center to keep my credit card on file to auto-charge copays or deductibles. Any unpaid patient balance on my account, a representative from Pediatric Therapy Center will contact me via phone to see how to handle any unpaid balance.

_____

Credit Card Number/ Type of Credit Card

_____

Expiration Date/CVV Code

_____ _____

Parent/Legal Guardian Date

_____ _____

Witness Date