Advanced Orthopedic
Physical Therapy, P.C.

Pediatric Intake Form

Thank you for choosing Advanced Orthopedic and welcome! Please assist us in getting to know your child by completing the following to the best of your knowledge.

Child's name: _____DOB: _____Age:_____Female: ☐ Male: ☐

Current Diagnosis: _____

Home Address: _____ Home Phone: _____

Email:_____

Mother's name: _____ Occupation: _____

Home Phone: _____ Cell Phone:_____ Work Phone: _____

Father's name: _____ Occupation: _____

Home Phone: _____ Cell Phone:_____ Work Phone: _____

Emergency Contact: _____ Relationship:_____ Phone Number: _____

Child's Primary Care Physician: _____ Phone/Address: _____

Child's Referring Physician: _____ Phone/Address: _____

Please list names of specialists you child has seen and their conclusions/suggestions: _____

_____

_____

Language spoken at home: _____

Name and ages of all household members: _____

_____

With whom does child spend most of his/her time? _____

List child's most prominent likes and dislikes: _____

What concerns you about your child? _____

_____

Is your child aware of his/her challenge? If yes, how does he/she feel about it? _____

Special equipment used by your child:

Wheelchair ☐ Braces ☐ Walker ☐ Glasses ☐ Hearing aides ☐ Communication Device ☐

Other:

Prenatal and Birth History

How was mom's general health during pregnancy (illness, accidents, medications, unusual condition, ect.)

_____

_____

Length of pregnancy: Less than 30 weeks ☐ 30-36 weeks ☐ 37-40 weeks ☐
Type of delivery: vaginal ☐ c-section ☐ VBAC ☐ induction ☐
Length of labor: _____ Birth Weight: _____ Length: _____

General condition of baby at birth: _____

_____

Medical History

Has your child experienced any of the following illness or conditions?
Asthma ☐ Croup ☐ Ear infections ☐ Encephalitis ☐
Headaches ☐ Ear Tubes ☐ High Fever ☐ Seizures ☐
Fractures ☐ specify location:
Is your child allergic to latex? Yes ☐ No ☐
Has the child had any surgeries, major accidents, or hospitalizations? If yes please describe: _____

_____

_____

Developmental History

Provide approximate ages at which your child performed the following:

Crawling_____ Sitting _____ Standing_____ Walking: _____

Does your child have difficulty participating in activities that require…
Small muscle coordination: Grasping ☐ Pinching ☐ Reaching ☐ Cutting ☐ Drawing ☐
Building block towers ☐ Other:

Describe your child's response to sound:
Responds to all sound ☐ Inconsistently responds to sounds ☐
Responds to loud sounds only ☐ Responds emotionally to sound ☐

How does your child usually communicate?
Gestures ☐ Single words ☐ Short phrases ☐ Sentences ☐
Own language ☐ Sign language ☐ Other:

Are there or have there ever been any feeding problems?
Sucking ☐ Swallowing ☐ Drooling ☐ Chewing ☐ Coughing/Choking ☐ Other:
If yes, please describe:_____

How does your child interact with others? Shy ☐ Aggressive ☐ Uncooperative ☐
Makes eye contact ☐ Plays on own ☐ Plays well with others ☐
Plays near others but not necessarily with them ☐ Able to establish and maintain friendships ☐
Abe to initiate play and take turns ☐ Other:

Does your child receive special services? If yes please identify _____

Has an Individual Education Plan (IEP) been developed for your child? If yes, please list most important goals:

_____

_____

Would you like copies of your child's report sent to anyone? If yes indicate name, fax or mailing address below

_____

_____

What are your goals for our time together? _____

_____

_____

Consent to Physical Therapy Intervention

I hereby authorize the healthcare providers of Advanced Orthopedic Physical Therapy to administer physical therapy interventions and procedures, as they deem professionally and clinically necessary. I understand that physical therapy interventions may include, but are not limited to: electrical/thermal modalities, therapeutic exercise, hands on manual therapy and manipulation and instrument assisted soft tissue mobilization. I understand that every attempt to explain each intervention will be made by the treating clinician. I acknowledge that I have the right to inquire about the clinical rationale for each intervention performed. I understand that physical therapy is a voluntary healthcare service and I, or the treating clinician, may choose to discontinue any intervention at any time. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the physical therapy intervention.

Person completing this form: _____ Relationship to child: _____

Signature: _____ Date: _____

Advanced Orthopedic
Physical Therapy, P.C.

700 Deborah Rd Ste 190B
Newberg, OR 97132
Phone 503-537-7070 FAX 503-395-1911

Patient

Name (Last, First)	Age	Birth Date	Sex
Mailing Address	City	State / Zip Code	Marital Status
Primary Diagnosis	Primary Numeric Diagnosis	Secondary Numeric Diagnosis	

Responsible Party

Name (Last, First)	Age	Birth Date	Sex	Relationship to Patient
Address (put same if same as above)	City	State	Zip Code	Marital Status
Employer	Home Phone	Cell Phone		

Referring Provider

Name (Last, First)	Phone	Fax

Primary Insurance Information

Primary Insurance Company	Policy Holder Name	Date of Birth	Policy Number
Insurance Address	City / State	Zip Code	Group Number
Phone Number	Co-Insurance %	Co-Pay	Deductible

Secondary Insurance Information

Secondary Insurance Company	Policy Holder Name	Date of Birth	Policy Number
Insurance Address	City / State	Zip Code	Group Number
Phone Number	Co-Insurance %	Co-Pay	Deductible

Signature of insured or authorized person	Date

FINANCIAL RESPONSIBILITY

I authorize Advanced Orthopedic Physical Therapy, PC to bill my insurance and receive direct payment from my primary insurance as well as my secondary insurance companies so that Advanced Orthopedic Physical Therapy, PC will be paid for the therapy services provided. Furthermore, I understand that I am financially responsible for any fees not paid or covered by my insurance providers. I also acknowledge that I am responsible for co-pays, co-insurance and deductibles which are included as part of my insurance contracts. I understand that if my account is more than 60 days past due I may be charged a $30 fee.

By signing this form, I understand and agree that (regardless of insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.

_____ _____

Patient Name Date

X_____ _____

Signature Relationship

X_____ _____

Witness Date

CANCELLATION POLICY

Advanced Orthopedic Physical Therapy, PC takes the care of our patients and their families very seriously. It is very important to us that you attend your regularly scheduled appointments. These scheduled appointments are part of a recommended treatment plan aimed at improving health, function, and the overall quality of life of our patients. Without regularly attending your scheduled appointments, the benefits of therapy will be limited.

Therefore, any appointments not cancelled by 8:30 AM the day of the appointment will incur a cancellation fee of $30.

If more than 2 cancellations/no shows occur within a patient's recommended plan of care timeframe, Advanced Orthopedic Physical Therapy, PC will hold the right to recommend discontinuing therapy services. The patient will then be removed from their therapist's schedule to allow for other individuals to use this time slot.

_____ _____

Client/Guardian Signature Date

_____ _____

Witness Date

Video and Picture Release

_____ I give permission for my child's picture/video to be used by Advanced Orthopedic Physical Therapy, PC for the purpose of training other professionals or paraprofessionals.

_____ I give permission for my child's picture/video to be used by Advanced Orthopedic Physical Therapy, PC for marketing/publicity.

_____ I do not wish my child's picture/video to be used for any purpose.

_____ _____

Patient Name Date

X_____ _____

Signature Relationship

X_____ _____

Witness Date

Consent to Release/Receive Medical Information

We understand the importance of coordinating and communicating with other persons involved in your child's development. We encourage you to provide us with contact information of other professional(s) working with your child.

I agree to let Advanced Orthopedic Physical Therapy, PC share and receive information from other agencies (organizations) about my child so services can be coordinated and optimized for my child's benefit. The following organizations are included in this release:

Medical Professionals:

_____

Schools/Teachers:

_____

Other:

_____

Please Note: Advanced Orthopedic therapists are available to meet with your child's educational or treatment team outside of a normal treatment session. These consultations are charged at the rate of an individualsession. These include consultations with parents, other professionals and teachers regarding your child's treatment.

_____ _____

Patient Name Date

X_____ _____

Signature Relationship

X_____ _____

Witness Date

Advanced Orthopedic Physical Therapy, P.C.

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclose personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(II), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1196 (the "Privacy Regulations").

Please read the following information carefully:

1 I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Advanced Orthopedic Physical Therapy, P.C (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2 I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3 I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 5465 Route 8, Gibsonia, PA 15044, Attention: Practice Compliance Director

4 I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by the restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____
_____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____ _____
Patient's Name Date of Birth

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

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To Be Completed by the Practice
The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____Accepted _____Denied _____Not Applicable

_____ _____
Signature of Authorized Practice Representative Date