

PEDIATRICS HEALTH QUESTIONNAIRE



Date: _____

Name: _____ **DOB:** ___ / ___ / ___ **SS#** _____ - _____ - _____

Street: _____ **City** _____ **State** _____ **Zip** _____

Home Phone # () _____ - _____ **Cell #** () _____ - _____ **Work#** () _____ - _____

Parent's (Guardian's) Name(s): _____

Email Address: (Please print neatly) _____

Do we have permission to contact you by email? Yes _____ No _____ Your email is for internal use only and will not be sold to third parties.

Referring Physician: _____ **Physician's PH#:** () _____ - _____

Emergency Contact's PH# () _____ - _____ **Relationship:** _____

Insurance Cardholder's Name: _____ **DOB:** ___ / ___ / ___

Were there any problems during pregnancy or delivery?

Have there been any hospitalizations since birth?

If this is a long term problem, when was it first noted?

Is your child in any pain? If yes, please describe where and when pain occurs.

At what age did your child do the following?

Roll _____ **Walk** _____
Sit Alone _____ **Hold Bottle** _____
Crawl _____ **Feed self** _____
Stand with help _____ **Dress self** _____
Stand Alone _____

Is your child on any medications?

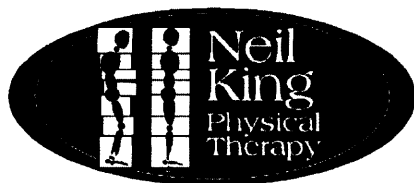
Does your child have any other medical problems, i.e. seizure, asthma, allergies?

Is your child receiving therapy now or in the past? Please list where and when treatment was received.

What are your goals for therapy?

Parent Signature _____ **Date** _____

Printed _____



**141 HAMPTON CIRCLE
ROCHESTER HILLS, MI 48307
(248) 853-7555**

BLUE CROSS BLUE SHIELD

We **accept** assignment from Blue Cross, but the insurance checks **may be made out to you and sent to you**. When you receive these checks in the mail, please bring them in along with the Explanation of Benefits (we will make a copy of the paperwork and return the original to you). You should receive the first check approximately 3-4 weeks after your first visit and then one a week until your final visit has been paid. After you have been discharged, please mail us the remaining checks along with a copy of the Explanation of Benefits.

Please sign at the bottom of this page to insure that you have been informed of this policy. Thank you for your cooperation in this very important matter.

SIGNATURE: _____ **DATE:** _____



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NOTICE OF PRIVACY PRACTICES AND CONSENT FORM

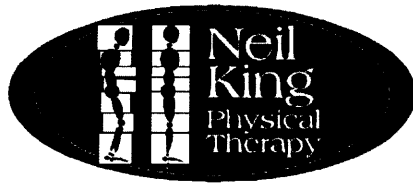
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. Before we begin any healthcare treatment we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this physical therapy office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this physical therapy office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. We may use or disclose your health information to your attending and referring physician.
3. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
4. Patients have the right to receive a copy of their health record in electronic format if records are stored in electronic format. The request will be processed within 30 days with a one times 30 day extension if required.
5. A patient's written consent need only be obtained one time for all subsequent care given in this office.
6. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for any care given prior to the request to revoke consent, but would apply for any treatment given after the request has been received.

7. As stated in #3 we must disclose your health information to you. We may also disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or payment for your healthcare, but only if you agree that we may do so.
8. Patients 18 years and older will be considered as an adult and will be responsible for making their own decisions.
9. We may use or disclose your health information to provide you with appointment reminders, such as voicemail messages or letters.
10. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
11. The patient has the right to request that information not be sent to their health plan when the patient is paying out of pocket in full for the service(s) performed.
12. Patients have the right to file a formal complaint with our privacy official about any possible violation of these policies and procedures.
13. If the patient refused to sign this consent for the purpose of treatment, payment and healthcare operations, the physical therapist has the right to refuse treatment.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

SIGNATURE: _____ **DATE:** _____



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To Our Patients Regarding

Cancellations and No-Shows

- The following are our policies regarding cancellations and no-shows. We take this subject very seriously at the clinic, because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you to achieve your goals in treatment.
- We require 24 hours' notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)
- There is a \$25.00 charge for a cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally.
- For Worker's Compensation and Personal Injury patients documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.
- You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.

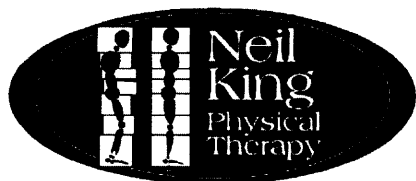
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a) you're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for wind-surfing. Neither of these conditions is legitimate as a reason not to come: a) if you're in pain, come in and get it fixed, b) if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem and educate you so you won't re-injure yourself, etc.

When you don't show as scheduled, three people are hurt; You, because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist, who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard. We're looking forward to working with you.

SIGNATURE: _____ **DATE:** _____

INTERVIEWER SIGNATURE: _____ **DATE:** _____



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PAYMENT PROVISIONS AUTHORIZATION

The term "healthcare benefits" in the following paragraphs means Medicare, Medicaid, maternal and infant health benefits, BCBS, commercial health insurance benefits, health maintenance organization, preferred provider organization, or managed care plan coverage, as applicable.

I request payment on my/the patient's behalf of all health care-benefits for services provided by Neil King PT.

I assign and transfer to Neil King PT all health care benefits applicable to my/the patient's care. I authorize and direct that all such health care benefits be paid directly to Neil King PT.

I understand that my insurance benefits were verified with my insurance company at the beginning of my treatment, and the deductible amount may change based on what was verified. I am also aware that during my treatment my deductible may reset and my account will be adjusted accordingly, and I will be responsible for any and all charges that may occur.

I understand that while I am being treated by Neil King Physical Therapy, it is my responsibility to notify them of any changes in my insurance coverage. Any additional charges (deductible, co-pay, etc.) will be the patient's responsibility. If a new insurance requires pre-authorization & patient doesn't notify us, then the patient will be responsible for all the therapy sessions rejected by the insurance company.

I agree personally to pay for any physical therapy charges not covered by or collected from any applicable health care benefit program, including any deductibles and coinsurance amounts.

I certify that I have read this for and that I understand it and consent to it. If the signer is not the patient, the signer certifies that he is the patient's duly authorized representative.

SIGNATURE: _____ **DATE:** _____