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 E-Mail? Yes ___ No ___ If no selection is made, you will automatically be added as a Yes. 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 _____

Neil King Physical Therapy

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 REFERING DOCTOR AND/ OR YOUR THERAPIST HAVE PRESCRIBED A SET FREQUENCY TREATMENT. SHOWING UP AS SCHEUDULED 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 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 THE FULL PRESCRIBED NUMBER OF TREATMENTS THAT WEEK WHENEVER POSSIBLE. IN SOME CASES, YOU MAY HAVE SEQUENTIAL DAYS OF TREATMENT.
- 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 CARE PHYSICAN AND THIS WOULD JEOPARDIZE YOUR CLAIM.
- YOU MAY NEED TO SEE A THERAPIST OTHER THAN THE ONE WHO NORMALLY TREATS YOU IF YOU 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(S) IN THE NEXT REGULARLY SCHEDULED VISIT.

PLEASE UNDERSTAND YOUR PAIN WILL PROBABLY INCREASE AND DECREASE OVER THE COURSE OF TREATMENT. EITHER CONDITION CAN SEEM TO BE A REASON NOT TO COME IN.

A) YOU'RE FEELING WORSE AND THINK THE TREATMENT IS NOT WORKING

B) YOU'RE FEELING BETTER AND IT IS A GREAT DAY FOR WIND-SURFING. NEITHER OF THESE CONDITIONS IS LEGITIMATE AS A REASON NOT TO COME

A) IF YOU ARE IN PAIN, COME IN AND GET IT FIXED,

B) IF YOU ARE OUT OF PAIN, NOW IS THE TIME WE CAN BEGIN DOING SOME REAL PROGRESSION OF THE UNDERLYING CAUSES OF YOUR PROBLEM AND EDUCATE YOU, SO YOU WON'T RE-INJURE, 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; 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 WOULD HAVE GIVEN PROPER NOTICE.

PLEASE CO-OPERATE WITH US IN THIS REGARD. WE ARE LOOKING FORWARD TO WORKING WITH YOU.

SIGNATURE_____ DATE_____

INTERVIEWER SIGNATURE _____DATE_____

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 shall 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 use by the patient for purpose of payment. Be assured this office will limit the release of all the 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/her own records at any time and request corrections. The patient may request to know 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-time 30-day extension, if required.
5. A patient's written consent needs to 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 with your consent
8. Patient's 18 or older will be considered an adult and will be responsible for making their own decisions.
9. We may use or disclose your health information to provide you with an appointment reminder, 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 your office. We have taken all precautions that are know by this office to ensure your records are not readily available to those who do not need them.
11. The patient has the right to request information not to be sent to their health plan when the patient is paying out of pocket in full for the service(s) performed.
12. Patient's 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 I understand how my patient health information will be used and agree to these policies and procedures.

SIGN X_____ DATE_____

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, IF 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 PATIENTS CARE. I AUTHORIZE AND DIRECT ALL SUCH HEALTH CARE BENEFITS BE PAID DIRECTLY TO NEIL KING PT.

I UNDERSTAND 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 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 PATIENTS RESPOSIBILITY. IF A NEW INSURANCE REQUIRES PRIOR AUTHORIZATION & PATIENT DOES NOT NOTIFY US, THEN THE PATIENT WILL BE RESPONSIBLE FOR ALL THERAPY SESSIONS REJECTED BY THE INSURANCE COMPANY.

I AGREE TO PERSONALLY 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 I HAVE READ THIS FROM AND UNDERSTAND IT AND CONSENT TO IT. IF THE SIGNER IS NOT THE PATIENT, THE SIGNER CERTIFIES THAT HE OR SHE, IS THE PATIENTS DULY AUTHORIZED REPRESENTATIVE.

SIGNATURE X_____DATE_____