



**Patient Information**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First MI Last

( ) Male ( ) Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Student Status: ( ) Full-Time ( ) Part-time

Name of child's school: \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
First MI Last

Home Address: \_\_\_\_\_  
Street Address City State Zip Code

( ) Home or ( ) Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ( ) Work or ( ) Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

Would you like to receive appointment reminders via email? ( ) Yes ( ) No

Would you like to receive appointment reminders via text message? ( ) Yes ( ) No

Do you give permission to leave a message on your answering machine? ( ) Yes ( ) No

Emergency Contact: \_\_\_\_\_ Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Name Relationship to patient

**Physician Information**

Referring Physician: \_\_\_\_\_ Date of Next MD Appt: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Other Specialists: \_\_\_\_\_ Type: \_\_\_\_\_

Other Specialists: \_\_\_\_\_ Type: \_\_\_\_\_

Other Specialists: \_\_\_\_\_ Type: \_\_\_\_\_

**Family Information**

Child lives with: ( ) both parents ( ) one parent: \_\_\_\_\_ ( ) other: \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_ Mother's Age: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_ Father's Age: \_\_\_\_\_

Are there other adults living at home: Yes ( ) No ( ) \_\_\_\_\_

Primary language spoken at home: \_\_\_\_\_

Name of Siblings	Gender	Age	Medical Diagnoses, Therapies Received



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**Consent to Treatment**

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Merrimack Valley Physical Therapy, LLC.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under age of 18): O Mother O Father O Legal Guardian

**Receipt of Notice of Privacy Practices Acknowledgement**

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understand the notice. Merrimack Valley Physical Therapy, LLC reserves the right to modify the privacy outlined in this notice.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under age of 18): O Mother O Father O Legal Guardian

**Release of Information**

This form is an important legal document. It indicates the people who you are granting the privilege to access your medical information that is obtained by MVPT. The information includes, but is not limited to; diagnosis, treatment, attendance, billing, and any results of tests that MVPT has received from your other health care providers Please complete the following information and then please print your name legibly and sign in the spaces provided at the bottom.

I grant the following person access to the medical record established and maintained by MVPT.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under age of 18): O Mother O Father O Legal Guardian

**Photo Release**

Photo release

- ( ) I consent to pictures being taken for the purpose of home exercise programs and caregiver education
- ( ) I consent to pictures being used for HEP / caregiver education and on the company website / social media
- ( ) I do not want any pictures taken of this child

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under age of 18): O Mother O Father O Legal Guardian



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### Financial Policy

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. I understand that I am responsible for all supplies, such as braces or exercise equipment, which I am provided during treatment if they are not covered by my insurance plan. I understand that I will pay for supplies upon receipt.

I hereby give authorization for payment of insurance benefits to be made directly to MVPT for services rendered. In the event that my insurance company forwards payment directly to me, instead of MVPT, I will immediately deliver said payment to MVPT.

I understand & agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due, upon demand. I understand and agree that if it becomes necessary for MVPT to utilize an outside collection agency or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance, and in addition attorney fees, court costs and other expenses of litigation.

I agree to release of medical or other information necessary to process my claim

**Signature of Person Responsible for Charges:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under age of 18):  Mother  Father  Legal Guardian

### Patient Commitment & Missed Appointment Policy

Thank you for choosing Merrimack Valley Physical Therapy; our staff will make every effort to ensure your experience here is both positive and productive so that you are able to achieve your functional goals. In order to give you the best possible outcome it is essential that you attend all your therapy appointments, as missing scheduled appointments greatly hinders progress toward your goals and may result in delaying your recovery.

In order to provide optimum outcomes and individualized care, we schedule our patients for one-on-one treatment times. We therefore respectfully require a 24 hour' notice for any appointment cancellation, which allows us the best opportunity to fill your appointment time with another patient who requires treatment.

**\*\*A 24 hours' notice is required for an appointment to be rescheduled\*\***

In an instance of a cancellation without 24 hours' notice or a no-show to a scheduled appointment, we reserve the right to charge a \$50 fee. Exceptions may be made in the case of an emergency, illness, or inclement weather. Please note that this charge cannot be billed to insurance and must be paid on or before the next scheduled appointment. While there may be situations in which you must (with proper notice) cancel your appointment:

- DO NOT CANCEL if you are feeling worse or believe the treatment is not working. Please understand that your pain will probably fluctuate as your course of treatment progresses. Keep your appointment and discuss any changes in your symptoms with your therapist.
- DO NOT CANCEL if you are feeling better; keep your appointment in order to progress your plan of care and prepare for discharge.

Thank you for your cooperation with this policy. Signing below indicates that you understand and agree to the terms of this policy.

**Signature of Person Responsible for Charges:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under age of 18):  Mother  Father  Legal Guardian



**Medical History**

Mother's health during pregnancy:      Excellent      Good      Fair      Poor  
 Complications: \_\_\_\_\_

Medications taken: \_\_\_\_\_

Pregnancy Duration \_\_\_\_\_ Birth Weight \_\_\_\_\_

Special Considerations

Prolonged labor \_\_\_\_\_ Induced \_\_\_\_\_ Breech \_\_\_\_\_ Premature \_\_\_\_\_

Multiple Birth (i.e. twin) \_\_\_\_\_ Caesarean \_\_\_\_\_ Vacuum/forceps \_\_\_\_\_

Baby's health at birth:      Excellent      Good      Fair      Poor

Please include any additional information such as: color, jaundice, anoxia, breathing problems, incubator, NICU stay etc.:

\_\_\_\_\_

\_\_\_\_\_

Does this child have any medical diagnoses (ADHD, Cerebral Palsy, Autism etc.): \_\_\_\_\_

\_\_\_\_\_

Hearing:      Has your child's hearing been tested?      Yes      No  
                  Does your child have / had PE tubes      Yes      No  
                  If yes, date inserted \_\_\_\_\_      Date removed \_\_\_\_\_

Vision:      Has your child's vision been examined?      Yes      No  
                  Findings: \_\_\_\_\_  
                  Does your child wear glasses?      Yes      No

Allergies? \_\_\_\_\_

**Medications** ( ) check if medication list attached, skip this section

Medication Name	Dosage	Frequency	Route (oral, topical, inhaler, injection)	Reason

At what age did your child

First sit? \_\_\_\_\_ First crawl? \_\_\_\_\_

First stand? \_\_\_\_\_ First walk? \_\_\_\_\_

Is your child potty trained? \_\_\_\_\_ If yes, at what age? \_\_\_\_\_

Has this child received therapy services in the past?      Yes      No

If yes, please include type of therapy, frequency, location \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_



	Yes	No	Age	Additional Details
Ear Infections				
Frequent colds/sinus infections				
Tonsils / adenoids removed				
Seizures / convulsions				
Asthma				
Hospitalization				
Surgery / Botox				
Head Injury				
Feeding Tube				
Broken bones				
Sprains / Strain				
Leg braces / orthotics / casts				

Is this child receiving therapy currently? Yes No  
 If yes, please include type of therapy, frequency, location \_\_\_\_\_

Does this child have an IEP Yes No If yes, what type of special services, frequency, duration: \_\_\_\_\_

Does this child use any special equipment (wheelchair, assistive device, compression garments, splints, braces)? \_\_\_\_\_

**Goals**

What are the goals you would like to see accomplished in therapy? \_\_\_\_\_

Is there any other pertinent information you would like us to know? \_\_\_\_\_

**The above information is true to the best of my knowledge.**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under the age of 18):  Mother  Father  Legal Guardian

Bedford

Londonderry

Manchester

Nashua