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

Consent to Treatment

I authorize the physical therapists and/or doctors of MVPT Physical Therapy ("MVPT") to examine and subsequently provide treatment. I realize that exam and treatment procedures may also be performed by assistants, but under the direction of the physical therapists and/or doctors of MVPT Physical Therapy.
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. MVPT Physical Therapy 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 Physical Therapy. The information includes, but is not limited to; diagnosis, treatment, attendance, billing, and any results of tests that MVPT Physical Therapy 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 Physical Therapy.

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 Physical Therapy for services rendered. In the event that my insurance company forwards payment directly to me, instead of MVPT Physical Therapy, I will immediately deliver said payment to MVPT Physical Therapy.

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 Physical Therapy 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): O Mother O Father O Legal Guardian

Patient Commitment & Missed Appointment Policy

Thank you for choosing MVPT 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): O Mother O Father O Legal Guardian

Just for Kids
Pediatric Services of
MVPT
PHYSICAL THERAPY

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): O Mother O Father O Legal Guardian