NEW PATIENT INFORMATION

Pediatric Therapy Center

PLEASE PRINT

Today's Date: _____ 1st Therapy Visit OT / PT / ST Therapist Seen: _____

Child: _____ Date of Birth: _____ Age: ____ Sex: ☐ or ☐

Last Name First M.I. Month/Day/Year

_____ ( ) _____

Street Address City State Zip Code Area Code Phone #

Cell # Home # E-Mail

Mother's Name and Father's Name _____

_____ ( ) _____

Street Address (if different from above) City State Zip Code Area Code Phone #

Diagnosis per Physicians Referral: _____

_____ ( ) _____

Area Code Phone #

Pediatrician:

EMERGENCY MEDICAL RELEASE

In the event medical attention is required for your child while on the premises of Pediatric Therapy Center, it will be necessary to have your authorization and contact information.

Alternate: _____ Phone: _____

As legal guardian of the above named child, I give my permission to furnish emergency medical services for minor injuries received while in a therapy session. In the event the emergency is life threatening, I give my permission to contact emergency personnel on the behalf of my child.

_____ Date: _____

Parent/Legal Guardian Signature

CONSENT FOR TREATMENT and ASSIGNMENT OF BENEFITS

I hereby authorize Pediatric Therapy Center to:

1. Release any necessary information acquired in the course of my examination or treatment to my referring physician, health plan/insurance representative or attorney.

2. To initiate a complaint on my health to The Chief Insurance Commissioner and the internal Review Processing Board of my insurance carrier for untimely processing of insuring claims.

3. Assign all benefits for which I am entitled by my insurance carrier to Pediatric Therapy Center and understand that I am financially responsible for all charges whether or not paid by my insurance.

I hereby authorize Pediatric Therapy Center to provide appropriate evaluation and treatment as needed

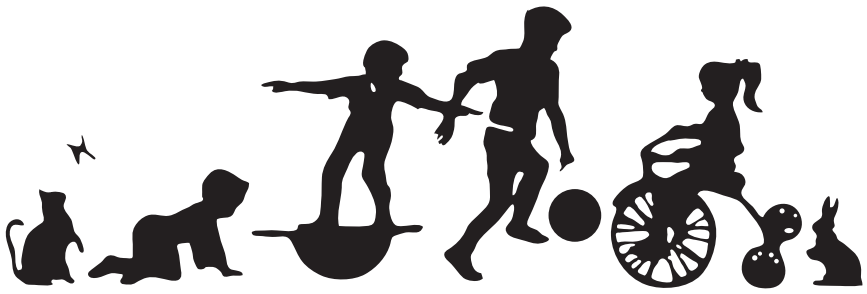
Signature: _____ Date: _____

(Parent/Legal Guardian Signature)

I have seen the attached HIPPA Notice of Privacy Practice. Initials _____

HIPPA Communication Consent Initials (emails) _____ Initials (text) _____

I understand that any information may not be secure and I will not hold PTC or any one of the workforce members liable for loss of any associated information transmitted by the above consented forms.



Pediatric Therapy Center

☐ RECURRING WEEKLY PAYMENT - OFFICE STAFF

☐ LEAVE INFO FOR GRANDPARENTS, NANNIES, ETC.

☐ NOT APPLICABLE

I, _____the parent/legal guardian of

_____ give my consent for Pediatric Therapy Center to keep my credit card on file to auto-charge copays or deductibles. Any unpaid patient balance on my account, a representative from Pediatric Therapy Center will contact me via phone to see how to handle any unpaid balance.

_____
Credit Card Number/ Type of Credit Card

_____
Expiration Date/CVV Code

_____ _____
Parent/Legal Guardian Date

_____ _____
Witness Date