Sprout Pediatric Therapy

Today's Date: _____

Patient Name: _____ Sex: _____ DOB: _____

Custody Status: ☐ Mother ☐ Father ☐ Joint ☐ Legal Guardian ☐ Custom_____

Guardian Name(s): _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Contact Numbers in Order of Preference:

Please note Information related to your child's treatment may be discussed or released with contacts listed below.

Appointment Reminder Method

Contact #1: (_____)_____ ☐ Home ☐ Cell ☐ Work ☐ Text ☐ Voice ☐ E-mail

Name: _____ Relation to Patient: _____

E-Mail: _____

Contact #2: (_____)_____ ☐ Home ☐ Cell ☐ Work

Name: _____ Relation to Patient: _____

Contact #3: (_____)_____ ☐ Home ☐ Cell ☐ Work

Name: _____ Relation to Patient: _____

Emergency Contact:(_____)_____ Name: _____

Relation to Patient_____

Primary Insurance Company: _____

Subscriber Name (if not patient): _____DOB: _____

Relation to Patient: _____

Secondary Insurance Company: _____

Subscriber Name (if not patient): _____DOB: _____

Relation to Patient: _____

Pediatric Occupational Therapy Intake Form

Name: _____ Date: ____/____/____

DOB: _____/____/____ Age: _____

Who referred you? _____

History

Pregnancy complications: _____

Delivery complications: _____

Medical diagnoses: _____

Allergies: _____

Current medications: _____

Previous surgeries: _____ History of ear infections: Y/N

Has your child's hearing been formally tested? Y/N

Has your child's vision been formally tested? Y/N

Current Complaint/ Concerns

Reason for referral to occupational therapy? Concerns/Goals for therapy?

_____

_____

_____

_____

_____

Physical Therapy Evaluation and Treatment

I consent to the rendering of a physical therapy evaluation and treatment as deemed appropriate by the treating therapist. I have the right to decline treatment at any time. Physical therapy is most effective if you participate according to the plan of treatment agreed upon with your therapist. If at any time you have questions or concerns, please talk with your therapist. Remember, we are here to provide you with the best care available in order to improve your quality of life through physical therapy.

Medical Insurance Authorization and Release

I authorize Waite Rehab & Wellness to correspond to my insurance company(s) as the provider of physical therapy services rendered at our facility. Waite Rehab & Wellness shall act as an agent in collection of payment from your insurance company(s), not limited to submission of medical records obtained at our facility as necessary for claim processing.

Patient Financial Responsibility

I accept full and complete financial responsibility for all medical services rendered to the registered patient and agree to any and all insurance co-payments, deductibles, and co-insurance that may be required under the terms of my medical insurance policies, as well as pay for any medical care that is considered a "non-covered" service under the terms of my medical insurance plan. I further acknowledge, understand and agree, that in the event that I fail to make payments in accordance with the expressed/implied payment policy of Waite Rehab & Wellness, or in the event of default of my financial obligation to pay for services rendered, Waite Rehab & Wellness reserves the right to forward all fees for-services to an external collection agency.

All applicable co-payments, co-insurance and deductible amounts are due at the time of service.

Missed Appointment Policy

Appointments that are canceled less than 24 hours in advance of the appointment time are considered late-notice cancellations. Instances where the patient has not arrived and signed in within 10 minutes of the appointment time is considered a missed appointment. Late-notice cancellations and missed appointments will each result in a $30.00 fee.

By signing below, I have read and agree to the above and certify that the information I have provided to Waite Rehab & Wellness is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Print name: _____ Social Security # _____