www.ptcnwfl.com

4624 Summerdale Blvd
Pace, Florida 32571
Phone: (850) 994-3456
Fax: (850) 994-3476

4100 S Ferdon Blvd Suite A-1
Crestview, FL 32536
Phone: (850) 682-8388
Fax: (850) 682-7463

Patient Information Form

Name: ____________________ DOB: ____________________

Parent/Guardian Names: ____________________

Address: ____________________ City ____________________ Zip ____________________

Phone Number: ____________________ Cell Phone Number: ____________________

E-mail: ____________________ Work Number: ____________________

Diagnosis (if known): ____________________

Primary Physician: ____________________

Physician's Phone and Address: ____________________

Other doctors and specialists who are involved in your child's care:

Name	Specialty	Phone Number

I give my permission for Kids Talk Place, LLC to exchange medical information about my child listed above with the preceding healthcare providers.

____________________ ____________________
* Signature * Printed Name

How did you hear about Pediatric Therapy Center NWFL? ____________________

☐ ***NEW INFORMATION!***

Insurance Information:

Primary Insurance: ____________________ Name of Insured: ____________________

Insured SS #: ____________________ Member ID: ____________________ Group # ____________________

Insured Date of Birth (required to bill) ____________________

Claims Address (found on back of card): ____________________

Customer Service #: ____________________

Secondary Insurance: ____________________ Name of Insured: ____________________

Member ID:________________________________ Group #:____

Claims Address (found on back of card):____ Cust Service #:__________

Is your child enrolled in the Early Steps program? ☐ Yes ☐ No Who is the service coordinator? ___________________

Are you interested in the Early Steps program? ☐ Yes ☐ No

☐ ***NEW INFORMATION!***
Family Background

Mother's Name: ____ Age: ________

Employer: ____

Father's Name: ____ Age: ________

Employer: ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Brother(s) and/or Sister(s) of the child:

Name	Age

Please list those authorized to bring your child to therapy and those we can release medical information to:

____ ☐ Therapy ☐ Release medical information

____ ☐ Therapy ☐ Release medical information

____ ☐ Therapy ☐ Release medical information

____ ☐ Therapy ☐ Release medical information

____ ☐ Therapy ☐ Release medical information

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Medical History

At how many weeks was your child born? ____________________ Birth weight? ________________________________

Were there any complications during the pregnancy or delivery? ☐ Yes ☐ No Please describe: ____________________

____

Was your child hospitalized after birth? ____

Does your child have any medical issues? ____

____

Does your child have a history of ear infections? ☐ Yes ☐ No Have PE tubes? ☐ Yes ☐ No

Please list any hospitalizations, surgeries and/or medical procedures your child has received:

____

____

Current medications:

Name	Dosage	Frequency	Reason for medication

Any known allergies (food, medications, environmental, etc) : ☐ Yes ☐ No. If yes, please describe:______________

____

____

Are there any precautions or restrictions? ____

Has your child ever experienced or been diagnosed with a seizure disorder? ___________________________________

State ages for the following milestones if mastered:

Babbling __________________________________
Stopped using bottle _________________________
Stopped using pacifier _______________________
Eating table foods ___________________________

First words _____________________________________
Sitting independently______________________________
Crawling _______________________________________
Walking independently _____________________________

Does your child drink from a sippie cup? _________________________ Open cup? _________________________

Does your child feed himself? _________________________________ Use a spoon? _______________________

Does your child have trouble with certain textures of foods? ____

Education Information

Is your child currently enrolled in school? ☐ Yes ☐ No

If “Yes”, where and days attending:____

Does your child receive any therapy services through the school? ☐ Yes ☐ No

If “Yes”, what services____________________What days are services received at school? __________________________

Does your child have a current Individualized Education Plan (IEP)? ☐ Yes ☐ No

What are your main concerns today?

____

Has your child previously received therapy services? ☐ Yes ☐ No

If “Yes”, where and when? ____

****Preferred time/day for therapy: ________________________________

Times/Days that are not good for your child: __________________________

______________________________	______________________________	______________________________
Name of Person Completing This Form	Relationship to Child	Date

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OFFICE POLICIES

1. Consistent attendance is important to your child's progress in therapy. We ask that you respect our time by providing our office with 24 hour notice if you are unable to attend at your appointed date and time. A call the day of your appointment will be accepted in emergencies or illness, but please notify our office as soon as you know you are not going to make your scheduled appointment. _____(initials)
2. If you have three "No Show" appointments or excessive cancelations you will be taken off the schedule. You will then need to contact our office when you are ready to attend therapy sessions on a regular basis again.
3. Signature below indicates that you received a copy of the HIPPA Notice of Privacy Practices.
4. I authorize payment of medical benefits to Kids Talk Place, LLC; for services rendered on behalf of the above named child.
5. I authorize physical therapy treatment, speech therapy treatment, occupational therapy treatment for the named child by licensed therapists or assistants, provisional licensed therapist, or externship clinicians/support personnel employed by or under contract to Kids Talk Place, LLC.
6. Our office will bill your private insurance company for your therapy charges. They will pay directly to our office a portion (the percentage or amount depends on <u>your</u> insurance contract with them) of the charges, <u>less</u> any deductibles, co-pays, and cost shares due. They will mail you a copy of the explanation of benefits (EOB). Some insurance companies send checks directly to the member. Any checks or EOBs you receive from an insurance company for services rendered at Pediatric Therapy Center NWFL or Kids Talk Place, LLC are due immediately to the provider upon receipt. _____(initials)
7. You are responsible for knowing your health insurance benefits and will be responsible for all deductibles, co-pays, cost shares or therapy visits that the insurance company does not cover. _____(initials)
8. You are responsible for any charges that your insurance company does not cover due to the policy not being effective, active, or for a change in their coverage of services (this includes all co-pays, cost shares, deductibles, etc). You are responsible for notifying Kids Talk Place, LLC of any changes in your insurance coverage. _________ (initials)
9. I understand that I am financially responsible for any services provided beyond those services authorized by Early Steps on my child's IFSP. _____(initials)
10. I further understand that it is my responsibility to inform Kids Talk Place, LLC of any changes in my address, phone number or insurance immediately. Failure to do so could result in incorrect processing of insurance claims thus making me responsible for any unpaid claims. _____(initials)
11. While we monitor authorization periods received from your insurance company and any state run program in which your child is enrolled, it is your responsibility to monitor the dates and advise us of those approaching expirations. Further, it is your responsibility to inform us if treatment authorizations are combined with other treatments that your child is receiving.
12. I understand and agree I am required to stay on premises during the child's therapy session.
13. I understand that if I have any unpaid bills and my account is turned over to collections that I am responsible for any incurred attorneys fees and charges.

I give my permission for my child to have their photograph taken and used in the clinic, in research, publications or on the website. No identifying information will be published about my child. __________yes __________no

I have read and fully understand the above stated policies. I have also received a copy of the HIPPA Notice of Privacy Practices.

_______________________________________ _______________________________________
Signature of parent or legal guardian Date

____Printed name of parent of legal guardian

____(Witness printed name and signature)