Pediatric Therapy Center
of Northwest Florida
Speech, Feeding, Physical & Occupational Therapy
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

30 S 3rd Street
Pensacola, FL 32507
Phone: (850) 994-3456
Fax: (850) 994-3476

Patient Information Form

Name: _____ DOB: _____

Parent/Guardian Names: _____

Address: _____City_____Zip_____

Phone Number: _____Work Number: _____Cell Phone Number: _____

E-mail:_____ Child's Social Security number: _____

Diagnosis (if known):_____

Primary Physician: _____

Physician's Phone and Address: _____

*Referring Physician (if different): _____

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 #:_____

Medicaid Number:_____ Effective Date:_____

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

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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 _____ First words _____
Stopped using bottle _____ Sitting independently_____
Stopped using pacifier _____ Crawling _____
Eating table foods _____ 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.
2. If you have three consecutive "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 your insurance contract with them) of the charges, less 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.
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.
8. I understand that I am financially responsible for any services provided beyond those services authorized by Early Steps on my child's IFSP.
9. 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.
10. 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.
11. I understand and agree I am required to stay on premises during the child's therapy session.
12. 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