Colleyville Physical Therapy & Sports Rehab

PEDIATRIC PATIENT INFORMATION

Child's Name: _____ DOB:_____Age:_____ Sex: M F

Address: _____ Apt:

City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____ Relationship to Child: _____

DOB: _____ Social Security No: _____ - _____ -

Address (if different from above: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Email: _____

Parent/Guardian Name: _____ Relationship to Child: _____

DOB: _____ Social Security No: _____ - _____ - _____

Address (if different from above: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Email: _____

How did you hear about us? __Physician __ Been Here Before __ Phone Book __ Internet __ Print Ad __ Walk-In

Child's Primary Physician: _____ Child's Referring Physician:_____

Reason for Referral: _____

PATIENT'S RELEASE OF INFORMATION AUTHORIZATION

There may be times when it is necessary for CPT to release personal health and or financial information to an individual that is not the patient. In accordance with Federal Regulations we can not release any information without written consent from the patient, please take a moment to complete this section. If you want us to discuss your information with (spouse, parent, neighbor and etc.), please list them below.

Financial Information: ____Yes ___No Medical Information: __Yes ___No Scheduling Appointment __Yes __NO

_____: This authorization will expire on this date: _____
_____: This authorization will expire upon my date of discharge.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient's Signature: _____ Date: _____

Benefit Release Information: I authorize **Colleyville Physical Therapy and Sports Rehabilitation, P.C.** to release any information necessary to my insurance carrier and/or their agents in order to determine benefits payable for related services. I authorize the payment of medical benefits for these services to **Colleyville Physical Therapy and Sports Rehabilitation, P.C.** I also authorize the release of all clinical information to my referring physician and primary care physician so that he or she can be updated on my condition and the care I receive here.

Signature: _____ Date: _____
(If the patient is a minor, please have the parent sign here.)

Authorization of treatment: I authorize **Colleyville Physical Therapy and Sports Rehabilitation, P.C.** to provide therapy services to myself_____ or to (my legal dependent) _____. I understand, I have the right to refuse therapy services at any time. I further understand no guarantees have been made by any representative of **Colleyville Physical Therapy and Sports Rehabilitation** as to the outcome of this therapy.

Signature: _____ Date: _____
(If the patient is a minor, please have the parent sign here.)

HIPAA Privacy Practices Acknowledgment: I have received the notice of privacy practices and I have been provided an opportunity to review it.

Signature: _____ Date: _____
(If the patient is a minor, please have the parent sign here.)

Cancellations and No-Shows: We take this subject seriously, because it can make difference between whether you succeed in your treatment or not. Showing up for these visits is very important in achieving your goals in therapy. Our appointments are made for an hour or greater, therefore when you do not show or fail to give adequate notice of a cancellation we are left with a large gap in our daily schedule, when another patient might have needed an appointment.

We require 24 hours notice of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.

There will be a $25.00 charge for a cancellation or no show without proper notice. This charge will not be covered by your insurance plan and is your responsibility. Worker's Compensation and PIP patients; documentation has to be made of any missed appointments and forwarded to your case manager and primary care physician.

Signature: _____ Date: _____
(If the patient is a minor, please have the parent sign here.)