Pediatric Patient Paperwork

Patient's Name: _____ Date of Birth:_____

Guardian's Name:_____ Relationship to Patient:_____

Email: _____ Preferred Phone Number: _____

Referring Provider: _____

What concern brings you in today?

_____

Birth History:

Child was born at: _____ weeks _____ days Birth weight: ____ lbs ____oz

Method of birth (check one): _____ Vaginal _____ C-section

Were there birth complications?_____ NICU stay?_____ How long?_____

If yes, please explain:

_____

Please list any prior surgeries your child has undergone:

Surgery	Date

Please list any medication your child is taking:

_____

Does your child have any allergies? Yes or No (*Circle*)

If yes, please list: _____

Does your child have seizures? _____

Has your child had the following screened?

Vision: _____ Results: _____ Date completed: _____

Hearing: _____ Results: _____ Date completed:_____

Swallow Study: _____ Results: _____ Date completed: _____

Please list any specialists that see your child:

_____

_____

_____

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Wellness Policy

At Saylor, we take your health and well being seriously. In order to avoid spreading illness, we ask that all patients and families follow these simple guidelines.

To attend your weekly appointment, we ask that you and your child are:

- Free of vomiting or diarrhea for 24 hours
- Fever free for 24 hours, without medication to assist with controlling fever
- At least 5 days out from a positive COVID test and able to wear a mask for the 5 days following OR at least 10 days out from a positive COVID test
- Free of contagion, including but not limited to: lice, bed bugs, ringworm, pink eye

By applying to these guidelines, we can best serve our patients and their families. Should you have questions or concerns prior to your therapy session, please contact your therapist.

I understand the Wellness Policy and will do my best to abide by these guidelines.

Patient's Name: _____

Guardian/Parent's Name:_____

Guardian/Parent's Signature: _____

Date: __ __/__ __ /__ __

Saylor Physical Therapy

Release of Information

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to obtain authorization before releasing written or verbal information regarding any patient. Please fill out the form accordingly. We thank you for your help and understanding.

I, _____, authorize Saylor PT and its staff to release information regarding my child's condition to the following people:

1._____
4._____
2._____
5._____
3._____
6._____

Patient's Name: _____ Guardian/Parent's Name:_____

Guardian/Parent's Signature: _____ Date __ __/__ __ /__ __

Note: Please include everyone's name that you are allowing for us to release information to including, but not limited to: spouse, school/other therapists, physicians (other than referring), prosthetist/orthotist, durable medical provider, relatives or friends. If the name is not listed above, we are unable to speak to or release information to them.

Payment Policy

It is our policy that patients and their families are directly responsible for their charges, if we are not a contracted provider with the patient's insurance company. Payment for services rendered for these coverages will be anticipated at the time of care. If your coverage is with a health care provider we are contracted with, the patient/family will be responsible for the patient's financial responsibility that the insurance company advises. The patient/family will be billed for the same after billing has been submitted, to and processed by, the insurance company. Charges applying to co-insurances, deductibles or copays reported will be considered the patient's caregiver's responsibility.

Patient's Name: _____ Guardian/Parent's Name:_____

Guardian/Parent's Signature: _____ Date: __ __/__ __ /__ __

Saylor Physical Therapy

Informed Consent

I, _____, hereby consent to voluntarily engage in a physical therapy and wellness training program recommended for the improvement of my child's general health, well-being and quality of life. I understand the intent of the program will be to provide rehabilitation, post-rehabilitation, fitness training, preventive conditioning and/or sport performance enhancement.

In order to determine my child's physical capacity to participate in an individualized goal-specific physical therapy and wellness program I acknowledge that a comprehensive examination is required. The exam will require full disclosure of my child's present medical condition, past medical history, and physical assessment. Physical assessment procedures will include an examination of my child's posture, range of motion, joint mobility, muscle flexibility, muscle strength, neurovascular status, and balance/coordination. I understand that I may be required to receive a physician's clearance for my child to participate in an individualized physical therapy and wellness program ***if*** the evaluating therapist deems it necessary after the initial examination. I consent to these procedures and agree, if necessary, to acquire a physician's approval to participate in the physical therapy and wellness training program.

I understand that this program may benefit my child's physical fitness or general health. However, the program cannot guarantee any particular level of improvement. I recognize that involvement in physical therapy and wellness training sessions will allow my child to learn proper ways to perform conditioning exercises, use fitness equipment, and regulate physical effort.

I understand and have been informed that there exists the risk of bodily injury during physical therapy sessions including, but not limited to, injuries to muscles/tendons, ligaments, joints and periarticular structures, and adverse responses such as abnormal blood pressure changes, lightheadedness, fainting, dizziness, abnormal heart rate changes and, in rare instances, heart attack, stroke, or death. Additionally, I understand that I must provide all medical related information, regarding my child, to the owners, operators, agents, employees, therapists, and instructors of Saylor PT if any problems, adverse symptoms, and/or desires to discontinue participation.

I have been informed that the information obtained in this program will be treated as privileged and confidential and will not be released to any person without my express written consent except as required by law. I agree to the use of any information for the purpose of consultation with other health/wellness professionals, including my child's doctor. Any other information obtained, however, will only be used by the owners, operators, agents, employees, therapists, and instructors of Saylor PT in the course of recommending interventions for my child and evaluating his/her progress in the program.
I have been given the opportunity to ask questions as to the procedures of this program and, by my signature, I fully consent to allow my child to participate in consideration of the aforementioned advisements.

Patient's Name: _____ Guardian/Parent's Name:_____

Guardian/Parent's Signature: _____ Date: __ __/__ __ /__ __

Saylor Physical Therapy

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my child's protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments, research, and physical therapist reviews.

I have received, read and understand the Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Saylor Physical Therapy at any time to address any concerns regarding the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my child's private information is used or disclosed to carry out treatment, payment, or healthcare options. I also understand you are not required to agree to my required restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: _____

Guardian/Parent's Name:_____

Guardian/Parent's Signature: _____

Date: __ __/__ __ /__ __

Saylor Physical Therapy

Cancellation Policy

Our physical therapists fully commit one hour of their time to your recovery and attending all scheduled visits is essential to this process. Saylor Physical Therapy believes that private, one-hour sessions are the quality of care that you deserve.

Effective January 1, 2019 our cancellation fee will be enforced. In order to provide private, one-hour sessions, we ask for you to give us at least a **24 hour** notification to cancel. If less than 24 hours notification is given, you will be responsible for the **cancellation fee of $75.** Thank you for your understanding in this important matter.

Additionally, please make sure you are on time for your appointments, and if 3 consecutive appointments are canceled with short notice, it is up to the therapist's discretion to cancel all upcoming visits until your schedule can accommodate consistent attendance.

Payment will be collected prior to ongoing therapy.

Thank you for your understanding of our policy.

Patient's Name: _____

Guardian/Parent's Name:_____

Guardian/Parent's Signature: _____

Date: __ __/__ __ /__ __

Social Media Consent Form

I hereby give Saylor Physical Therapy permission to take photos and/or videos of my child for the purpose of posting on Saylor Physical Therapy's social media platforms (Instagram, twitter, Facebook, Youtube, Clinic website, etc.).

I hereby release and discharge Saylor Physical Therapy from any and all claims arising from the use of photos and/or videos.

In signing this consent, I give authorization to use my child's photos and/or videos related to my experiences with Saylor Physical Therapy. I understand this information may be used in publications including but not limited to electronic publications, audio-visual presentations, promotional literature, and advertising.

I understand that I can revoke this release at any time in writing and that the use of any and all photos/videos or other information authorized by this release will immediately cease.

Please print and sign:

Patient's Name: _____

Guardian/Parent's Name:_____

Guardian/Parent's Signature: _____

Date: __ __/__ __ /__ __