

## New Patient Information

*Please print legibly:*

Patient Name: \_\_\_\_\_ Gender: Male Female

Diagnosis: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Parent(s)/Guardian(s): \_\_\_\_\_

Primary Physician: \_\_\_\_\_ PP Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ RP Phone: \_\_\_\_\_

Support Coordinator (if applicable): \_\_\_\_\_ SC Phone: \_\_\_\_\_

How did you hear about Kids Place? \_\_\_\_\_

Kids Place prefers to keep its business “in the family” when possible. Are you involved in a business that could develop a relationship with Kids Place (i.e. graphic design, office supplies, printing, construction, etc.)?

\_\_\_\_\_  
\_\_\_\_\_

### Emergency Contacts

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### Primary Insurance Information

Insurance Company Name: \_\_\_\_\_

Subscribers Name: \_\_\_\_\_ Subscribers DOB: \_\_\_\_\_

ID#: \_\_\_\_\_ Group/Policy Number: \_\_\_\_\_

Customer Service Phone Number (Located on back of insurance card): \_\_\_\_\_

### Secondary Insurance Information

Insurance Company Name: \_\_\_\_\_

Subscribers Name: \_\_\_\_\_ Subscribers DOB: \_\_\_\_\_

ID#: \_\_\_\_\_ Group/Policy Number: \_\_\_\_\_

Customer Service Phone Number (Located on back of insurance card): \_\_\_\_\_

## Developmental History

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Diagnoses: \_\_\_\_\_

Parent/Caregiver Primary Concern (s): \_\_\_\_\_

### Birth History

Weight: \_\_\_\_\_ Length: \_\_\_\_\_

Was your child born prematurely? Yes No If yes, what week was your child born? \_\_\_\_\_

### Delivery

\_\_\_\_\_ Spontaneous \_\_\_\_\_ Breech \_\_\_\_\_ Cord around neck

\_\_\_\_\_ Induced \_\_\_\_\_ Normal \_\_\_\_\_ Hemorrhage

\_\_\_\_\_ Cesarean \_\_\_\_\_ Infant Injured during delivery

Please explain: \_\_\_\_\_

\_\_\_\_\_ Positive for substances

Please explain: \_\_\_\_\_

### Post Delivery Period *(please complete only if there were delivery complications)*

\_\_\_\_\_ Jaundice \_\_\_\_\_ Cyanosis (turned blue)

\_\_\_\_\_ Intensive Care \_\_\_\_\_ Infection: \_\_\_\_\_

\_\_\_\_\_ Cerebral Bleed \_\_\_\_\_ Other Complications: \_\_\_\_\_

Number of days in the hospital after delivery for the child: \_\_\_\_\_

### Early Development *(please list all relevant milestones)*

Sitting Unsupported: \_\_\_\_\_ Crawling: \_\_\_\_\_

Walking: \_\_\_\_\_ First Word: \_\_\_\_\_

Toilet Trained: \_\_\_\_\_ Dress Self: \_\_\_\_\_

Please list all relevant surgeries: \_\_\_\_\_

### Background

Previous therapies (please check all that apply): PT OT SPEECH FEEDING VISION

Is your child receiving therapy services in school? YES NO

If yes, what services? \_\_\_\_\_ If yes, what school? \_\_\_\_\_

### Medications

Please list any and all medications that your child is currently taking: \_\_\_\_\_

## Financial Policies

**Please initial each section and sign below:**

AZOPT Kids Place is committed to providing the best possible care, and therefore, your clear understanding of our financial policy is important to our professional relationship. Please ask if you have questions about our fees, financial policy, or your financial responsibility.

AZOPT Kids Place will request a photocopy of the front and back of your insurance identification card and driver's license. Please update your card with any additional information your insurance company provides, which will facilitate the submission of claims on your behalf. It is your responsibility to inform us of any changes to your policy. We will bill your insurance company on your behalf as a courtesy.

### **Co-Payment/Co-Insurance**

\_\_\_\_\_ Initial

We must collect your carrier-designated co-pay at the time of service. Refusal to abide by this agreement may result in termination of your coverage.

AZOPT Kids Place will calculate an estimated co-payment or co-insurance based on your insurance policy. This amount will be due at the time of each appointment.

### **Missed Appointments**

\_\_\_\_\_ Initial

Patients who do not show up for an appointment, or call to cancel with less than 24 hours' notice have impacted other patient's ability to obtain timely medical care. Therefore, subject to the individual patients' insurance contract, **we reserve the right to charge a \$50.00 fee for no-show or same day cancelled appointments.**

### **Returned Checks**

\_\_\_\_\_ Initial

If a check is used as your form of payment, and that check is returned due to insufficient funds or the payment has been stopped, you will be charged a \$25.00 fee in addition to the amount of the check.

### **Insurance**

\_\_\_\_\_ Initial

We will gladly bill and accept payment from your health insurance plan. Any amounts not covered by your insurance carrier are your responsibility.

Communication between AZOPT Kids Place and our patients help us succeed in providing the best care. Please advise us if your insurance company has pre-certification and/or prior authorization requirements and/or policy restrictions and limitations.

### **Payments**

\_\_\_\_\_ Initial

You are responsible for any amount not covered by your insurance carrier. All co-payments and deductible amounts are due at the time of service. For your convenience, we do accept all major credit cards, checks, money orders, and cash.

### Patient or Guarantor

I have read and understand the above. I hereby authorize Arizona Orthopedic Physical Therapy, PLLC to submit claims to my insurance carrier. I hereby authorize direct payment of benefits, otherwise payable to me, to be made payable to Arizona Orthopedic Physical Therapy, PLLC. I understand I will be responsible for payment of any amounts not covered by my insurance carrier, including, but not limited to, co-payments and deductibles.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

## Kids Place Policies

*Please initial each section and sign below:*

\_\_\_\_\_  
Initial

### **Cancellation / No Show Policy**

As a team we have created a plan of care for your child to meet his/her therapy needs. Following this plan of care, and attending scheduled sessions, is important in order to meet your child's full potential. If you do not abide by the plan of care, your child may be removed from their permanently scheduled appointment. The following are examples:

#### **Your child misses two separate appointments without our office receiving a phone call.**

Failure to call and cancel your appointment at least four hours before your scheduled time is considered a no-show. We have a voice mail that is checked early so you may call after hours or early in the morning.

#### **Your child cancels three separate appointments within one quarter, without a hospitalization or a severe illness.**

Please note: a rescheduled appointment within the same week is not a cancellation.

\_\_\_\_\_  
Initial

### **Discharge Policy**

Your child's therapy needs may change during the course of treatment. The following conditions may result in your therapist recommending discharge from Kids Place:

#### **Plateau in function**

Kids Place is committed to creating an environment that allows each child to grow. Goals are updated each quarter based on areas of need and concerns. After each quarter, progress towards these goals is discussed with caregivers, and new/updated goals are established. If a child has reached a plateau and has not made progress in 6 months, the child may be discharged.

#### **Meeting all goals**

When a child meets all of their established goals, and there are no further functional or objective goals to meet, a child will be discharged.

I, \_\_\_\_\_, ( Patient Name: \_\_\_\_\_ ) have read and understand the above policies and hereby request and consent to the performance of therapy, including examination and diagnosis, of my child by Arizona Orthopedic Physical Therapy, PLLC. I consent to the treatment plan and intend this consent form to cover the entire course of treatment for my child's present condition and for any future conditions for which we seek treatment.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## Authorization for the Release of Medical Records

I hereby authorize Arizona Orthopedic Physical Therapy, PLLC to release the medical record(s) of:

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

For the purpose of continued treatment and billing/re-assignment of benefits, this allows AZOPT to bill on your behalf, and for the payment to be sent directly to AZOPT, to:

Arizona Orthopedic Physical Therapy, PLLC  
14557 W. Indian School Rd. #500  
Goodyear, AZ 85395  
Phone: 623-242-6908  
Fax: 623-242-6909

Signature of Guardian: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Notice of Privacy Practices

Your name and signature below indicate that you have received a copy of and/or have been directed to the Notice of Privacy Practices by Arizona Orthopedic Physical Therapy, PLLC, on the date indicated. If you have any questions regarding the information set forth in AZOPT's Notice of Privacy Practices, please do not hesitate to ask an AZOPT representative.

Signature of Guardian: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Photo Consent Release

I would like to extend permission to Arizona Orthopedic Physical Therapy, PLLC (AZOPT) to use my:

- Name                              Yes               No
- Testimonial                      Yes               No
- Image/photograph              Yes               No

in publications and advertisements produced by or for AZOPT. I understand that these publications will also be placed on web sites managed by AZOPT for public relations and advertising purposes. I understand that the publication may appear on the Internet, the publication may appear in print, electronic, or video media, and the publication may enable readers to identify me. I understand this consent is valid until I provide written notice stating otherwise.

Signature of Guardian: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_