"We look forward to the opportunity to serve you and your child."

Southern PEDIATRIC THERAPY Clinic

1620 HWY 11 N STE C
Picayune, MS 39466
P: 769-242-2139
F: 601-255-8629

Patient's Name:_____ Date of Birth: _____ Age: _____ Sex: M / F Address:

_____

City: _____ State: _____ Zip:_____ SSN: _____

Is this child in school? Yes / No Is the patient a foster child? Yes / No

Additional information regarding care, custody, contact, and restrictions: _____

_____

Guardian's Name (1): _____ Relationship to Child: _____

Address: _____ City: _____ State:_____ Zip:

_____ Preferred Phone: _____ Home / Work / Cell

Alt Phone: _____ Home / Work / Cell E-mail:_____

Guardian's Name (2): _____ Relationship to Child: _____

Address: _____ City: _____ State:_____ Zip:

_____ Preferred Phone: _____ Home / Work / Cell

Alt Phone: _____ Home / Work / Cell E-mail:_____

Emergency Contact: _____ Relationship: _____ Phone: _____

Physician/Pediatrician (Name and Facility):_____

Primary Insurance: Insurance Company: _____

Policy Holder's Name:_____ DOB:_____ SSN:_____

Secondary Insurance: Insurance Company: _____

Policy Holder's Name:_____ DOB:_____ SSN:_____

Significant medical conditions, surgeries, or injuries: _____

_____

Medications: _____

Allergies: _____

Please list any significant prenatal or birth history: _____

_____

Length of pregnancy (weeks): _____ C-section: No / Yes: Emergency / Planned?

Any complications after delivery? _____ NICU stay: No / Yes: _____ weeks

Has your child's hearing or vision been checked recently? Yes / No Results: _____

What are your primary areas of concern? _____

_____

What are your child's strengths? _____

_____

What are your family's goals for therapy? _____

_____

Please list any behavioral or social concerns: _____

Has your child ever received physical, occupational, or speech therapy before? Yes / No

Does your child use any adaptive equipment? No / Yes: _____

Does your child receive school therapy services or early intervention through an IEP or IFSP? Yes / No

Is there anything else that you feel would be beneficial for us to know about your child? _____

_____

_____

How did you hear about us? Who can we thank for your referral? _____

Thank you for taking the time to fill out this questionnaire. This information will help us to become more familiar with your child so that we can provide the best service possible to you and your child.

Patient's Name:_____

Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Signature: _____ Date: _____

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Please initial and date where indicated below:

Consent to Treatment

I hereby authorize the profession staff at **Southern Pediatric Therapy Clinic** to examine and treat me with physical therapy and/or occupational therapy for the Injury and/or Condition that I have been referred here for or referred myself to.

_____ _____
Patient / Caregiver Initial **Date**

HIPAA Regulations

I understand that **Southern Pediatric Therapy** complies with HIPAA and will protect my Protected Health Information (PHI). I understand my information will be used as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to my insurance company, adjuster, attorney, or medical provider for purpose of securing payment. This authorization remains in effect until 90 days from the date of last bill collected.

_____ _____
Patient / Caregiver Initial **Date**

Assignment and Instruction for Direct Payment to Health Provider

Insurance Company/Companies(S) _____

I hereby instruct the above-named insurance company/companies to pay by check made out to and mailed directly to **Southern Pediatric Therapy Clinic** for professional or medical expenses allowable and otherwise payable to me under my current insurance policy. This is a direct assignment of my rights and benefits under this policy**.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

_____ _____
Patient / Caregiver Initial **Date**