Patient Information

Patient Name____________________________________ Sex_______ Age______ Birth Date__________________

Address______________________________________ City/State/Zip_____________________________________

Home Phone___________________________________ Cell Phone____

Social Security#__________________________________ E-mail address:__________________________________

Employer____________________________________ Employer Phone Number____________________________

Referring Physician________________________________ Phone Number_____________________________

Primary Physician________________________________

Responsible Party

Mother/Guardian _________________________________ Father/Guardian________________________________

Phone _________________ DOB___________________ Phone __________________ DOB________________

Employer _______________________________________ Employer _____________________________________

Emergency Contact

Name_____________________________________ Relationship_____________________________________

Phone Number_______________________________________

Primary Insurance

Insurance Name__________________________

ID Number ___________________________

Group Number___________________________

Secondary Insurance

Insurance Name_______________________________

ID Number _______________________________

Group Number_______________________________

Is this an Auto Accident?_____ ____ Workman's Comp Claim____________ Date of Injury________________

Have you received any Physical, Occupational or Speech Therapy within the last 12 months? ____ Yes ____No
If Yes Where:____________________________________

By signing below I give consent to Primary Therapy Source to provide physical, speech, or/and occupational therapy for:_______________. I Understand and agree that, (regardless of my insurance status), that I am ultimately responsible for the balance on my account for any services rendered. I have read all the information contained on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.
I agree to notify Primary Therapy Source if I have previously seen another Physical Therapist or if I see another Physical Therapist during my treatment with Primary Therapy Source. If I do not notify Primary Therapy Source, I agree to pay for any unauthorized services that are not paid by my insurance.
I authorize Primary Therapy Source to release my records to their billing service, my insurance company and my physician. I understand that these records will be held in strict confidence and will not be released to any unauthorized person. I authorize payment of medical benefits to undersigned physician or supplier of services rendered.
Cancellations and No-shows given less than 8 business hours are assessed a $15.00 fee for each occurrence.

Signature____ Date________________________________

Authorization for Release of Information

Please complete and return this form to Primary Therapy Source

Patient Information

Name ____ Date of Birth _____________ Phone ___________

Mailing Address ___________________________________ City _____________ ST____ Zipcode _________

The names of parties authorized to exchange information:

I Authorize: Primary Therapy Source
254 River Vista Place
Twin Falls, ID 83301

(Check either box or both, as needed) ☐ to release information to: ☐ to obtain information from:

_________________________________ ____
Doctor (If more than one please use extra space below) Address

________________________ ___________________ __________ _________________
City State Zipcode Phone

____________________________________ _______________________________________
Organization (School, Preschools, etc….) Address

________________________ ___________________ __________ _________________
City State Zipcode Phone

____________________________________ ____
Name Address

________________________ ___________________ __________ _________________
City State Zipcode Phone

Please Disclose the following (please check):

_____ Treatment Records
_____ Evaluation(s)
_____ Progress Notes
_____ Other ____
_____ Medical Evaluation(s)
_____ Service Coordination Plan
_____ IFSP/IEP

By Signing authorization, I understand that the parties named above are permitted to exchange written and verbal information regarding myself or my child as a patient. The authorization will expire within one year of the signature date. I understand that at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. I may submit my written statement of revocation to Primary Therapy Source office. I understand that the person of entity who receives my confidential information may not be required to prevent unauthorized use or disclosure. I understand that my signature on this form is not required to treatment, payment, enrollment, or eligibility for benefits and that a copy of this authorization shall be valid as the original.

Print Name _________________________________

Signature _____________________________________ Date_____________________________

APPOINTMENT POLICY

Effective June 3, 2013

It is crucial that you follow the appointment schedule that has been set by Primary Therapy Source. Following your physician's and therapist's advice, as well as coming to therapy at your appointed time will help you achieve your health goals.

We understand that there are times when you must miss an appointment due to illness, emergencies or unexpected responsibilities for work or family.

However, it has been our experience that most of the time, missed appointments are not due to emergencies. When you do not call to cancel an appointment, you are preventing another patient from getting much needed treatment. Also, when another patient fails to cancel, we could be unable to schedule you for a visit, due to a seemingly "full" appointment book.

To ensure that all of our patients have access to the highest level of care, Primary Therapy Source has developed the following policy:

If you do not call to reschedule or cancel an appointment at least 24 hours in advance, you will be charged a $15 no show fee. This fee is **NOT** covered by your insurance company or Medicaid and will be due before the next appointment.

ILLNESS: If your child is ill, **WE ALLOW THREE (3) SICK DAYS IN A SIX (6) MONTH PERIOD** **provided** you call to notify us your child is out sick. If you do not notify the office before your child's appointment, the appointment will be considered a missed appointment and subject to the no show fee.

I understand and agree to abide by the above policy.

___________________________________ ________________________________

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, ____, have received a copy of this office's Notice of Privacy Practices

____
(Please Print Name)

____
(Signature)

____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

PRIMARY THERAPY SOURCE

Pediatric History

Child's:
Last Name: ____________________ First Name: __________________Middle Initial:______ Birth date: ___________

Circle Selection: Preterm / Full term infant Female / Male
SSN: _________________ Telephone #:________________ Address:____________________________________
City: ________________________ State: ____________ Zip:______________________
Parent or Responsible Party:____
Telephone & address if different than minor's Primary language:__________________
____
Second language: __________________

Social: Parents are: ____Married _____Separated _____ Divorced _____Single

Child lives with: ____
Does the child have siblings? ____No ____Yes If yes, number and ages: ______________________
Was this child one of a multiple birth? ____No ____Yes If yes, indicate: ____Twins ____Triplets ____Quads ____Quints
Do you have stairs inside your home?____No ____Yes
Do you have transportation available? ____No ____Yes

Reason for therapy?

Please indicate if birth mother had any of the following problems during the pregnancy:
_____Pre-eclampsia
_____Diabetes
_____Thyroid problems
_____Edema
_____Excessive weight gain: _____Pounds gained
_____ Dehydration
_____ Premature labor
_____ High Blood pressure
Other:_____________
____
How many pregnancies did the birth mother have? ________ How many live births?_________

Did the birth mother:
Take drugs that were prescribed?
Take over the counter drugs during the pregnancy?
Smoke during pregnancy?
Drink alcohol during the pregnancy?

Does the child have:
Vision impairment? ____No ____Yes If yes, describe:

Hearing Impairment? ____No ____Yes If yes, describe:
Family History: Are there any other family members with similar problems? ____No ____Yes
If yes, describe:

Birth History: Where did the birth take place? ____Hospital ____Home ____Birthing Center
____Other – Please explain:
Type of delivery: ____Vaginal ____C-Section Did the baby present breech? ___No ___Yes
Were forceps used? ___No ___Yes Was vacuum extraction used? ___No ___Yes

What was the baby's birth length?	What was the baby's APGAR score?	How long was the baby in the hospital? Was the baby in the NICU?
What was the baby's weight?	Did the baby need ventilator support?	How long was the mother in the hospital?

Please indicate any diagnostic tests the baby/child has had:

Medications: Prescription:
Over the counter:

Please Check as Applicable:	**YES**	**NO**	**DESCRIBE:**
Respiratory Problems			
Seizures			
Muscle spasms			
Head injury			
Falls			
High fevers			
Heart problems			
Shunt placement			
Failure to thrive			
Loss of consciousness			
Dehydration			
Abnormal bleeding &/or bruising			
Abnormal growth			
Loss of weight			
Diabetes			
Thyroid dysfunction			
Urinary or bowel problems			
Gastrointestinal			
HIV			
Wheezing, coughing during/after activity			
Agitation			
Excessive sleeping			
Allergies			
Other:			

Development age of child:_____ Normal ____ Delayed____

Explain:

Recent weight changes: Weight gain______ Weight loss _______
Describe:

Other services:

General nutrition:

Feeding difficulties? Explain:

Please indicate any other information that may be important or you wish to discuss:

The above information is accurate and true to the best of my knowledge, and I give my consent for the evaluation to be performed.

Signature of responsible party if client is a minor: _________________________ Date:______________
Printed name:________________________ Relationship to the child: ____________________________