Interact Pediatric Therapy Services, PLLC

5603B W Friendly Ave. Ste #274 Greensboro, NC 27410

Patient Information Form

Name: _____ DOB: _____

Parent/Guardian Names:_____

Address: _____ City_____Zip_____

Phone Number: _____Work Number: _____Cell Phone Number: _____

E-mail:_____ Please circle preferred method of communication

Diagnosis (if known): _____

Primary Physician (Phone and Address): _____

_____

Referring Physician (if different):_____

Other doctors and specialists who are involved in your child's care:

Name	Specialty	Phone Number

I give my permission for Interact Pediatric Therapy Services, LLC to exchange medical information about my child, _____ with the preceding healthcare providers.

_____ _____

Signature Printed Name

How did you hear about Interact Pediatric Therapy Services?

_____

Insurance Information:

Primary Insurance:_____ Name of Insured:_____

Insured SS #:_____ Member ID:_____ Group #_____

Claims Address (found on back of card):_____

Customer Service #:_____

Secondary Insurance:_____ Name of Insured:_____

Member ID:_____ Group #:_____

Claims Address (found on back of card):_____

Cust Service #:_____ Medicaid Number:_____

Effective Date:_____

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Is your child enrolled in the CDSA? Yes No Who is the service coordinator? _____

Family Background
Mother's name_____ Age_____

Occupation _____

Father's Name_____ Age_____

Occupation _____

Marital Status: Single Married Divorced Separated Widowed

Brother(s) and/or Sister(s) of the child (name and age)_____

_____
What are your goals in coming to therapy?
_____

_____

_____

Has your child previously received therapy services? Yes No

If yes, when and where? _____

Medical History
At how many weeks was your child born? _____ Birth weight? _____

Were there any complications during the pregnancy or delivery? Yes No

Please describe: _____

_____

Was your child hospitalized after birth?
_____

Does your child have any other medical issues?
_____

_____

Does your child have a history of ear infections? Yes No Have PE tubes? Yes No
Please list any hospitalizations and/or medical procedures your child has received:
_____

_____

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Current medications:

Name	Dosage	Frequency	Reason for medication

Any known allergies: Yes No If yes, please describe:_____

_____

Are there any precautions or restrictions? _____

Has your child ever experienced or been diagnosed with a seizure disorder? _____

State ages for the following milestones if mastered:

Babbling _____ Stopped using bottle _____
Stopped using pacifier _____ Eating table foods _____
First words _____ Sitting independently_____ Walking independently _____

Does your child drink from a sippie cup? _____ Open cup? _____

Does your child feed him/herself? _____ Use a spoon? _____

Does your child have trouble with certain textures of foods?_____

Education Information
Is your child currently enrolled in school? Yes No
If yes, where and days attending _____
Does your child receive any services through the school? Yes No What days are services received at school? _____ Does your child have a current Individualized Education Plan (IEP)? Yes No

Social/Emotional History
_____
_____
_____
_____
_____
_____

Anything else you would like to tell us about your child or family?
_____
_____
_____

****Preferred time/day for therapy: _____ Times/Days that are not good for your child: _____
Name of Person Completing This Form_____ Relationship to Child_____
Date_____

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Interact Pediatric Therapy Services Polices

1. We ask that you respect our time by providing our office with 24 hour notice if you are unable to attend at your appointed date and time. A call the day of your appointment will be accepted in emergencies or illness, but please notify our office as soon as you know you are not going to make your scheduled appointment.
_____initials

2. If you have three no shows or excessive cancelations, you will be taken off the schedule. You will then need to contact our office when you are ready to attend therapy sessions on a regular basis again.
_____ initials

3. I authorize payment of medical benefits to Interact Pediatric Therapy Services, PLLC; for services rendered on behalf of the above named child. _____initials

5. I authorize physical therapy treatment, speech therapy treatment, occupational therapy treatment for the named child by licensed therapists or assistants, provisional licensed therapist, or externship clinicians/support personnel employed by or under contract to Interact Pediatric Therapy Services, PLLC.
_____initials

6. Our office will bill your private insurance company on a monthly basis for your therapy charges. They will pay directly to our office a portion (the percentage or amount depends on your insurance contract with them) of the charges, less any deductibles, co-pays, and cost shares due. They will mail you a copy of the explanation of benefits (EOB). Some insurance companies send checks directly to the member. Any checks or EOBs you receive from an insurance company for services rendered at Interact Pediatric Therapy Services, PLLC are due immediately to the provider upon receipt. _____initials

7. You are responsible for knowing your health insurance benefits and will be responsible for all deductibles, co-pays, cost shares or therapy visits that the insurance company does not cover. Copays are due at the time of service and will be collected by your therapist at each appointment
_____initials

8. I understand that I am financially responsible for any services provided beyond those services authorized by insurance or Childrens Developmental Services Agency
_____initials

9. I further understand that it is my responsibility to inform Interact Pediatric Therapy Services, PLLC of any changes in my address, phone number, or insurance immediately. Failure to do so could result in incorrect processing of insurance claims thus making me responsible for any unpaid claims.
_____ initials

10. While we monitor authorization periods received from your insurance company and any state run program in which your child is enrolled, it is your responsibility to monitor the dates and advise us of those approaching expirations. Further, it is your responsibility to inform us if treatment authorizations are combined with other treatments that your child is receiving. _____ initials

I have read and fully understand the above stated policies. I have also received a copy of the HIPPA Notice of Privacy Practices.
I give my permission for my child to have their photograph taken and used in the clinic, in research, publications or on the website. No identifying information will be published about my child.

_____yes _____no
_____ Date

_____ Signature of parent or legal guardian
_____ Printed name of parent of legal guardian
_____ Witness Signature
_____ Printed name of witness
_____ Date