PATIENT REGISTRATION

Date: _____ **Date of next MD visit** ___/___/___ **Date last seen** by referring MD: ___/___/___

Patient Last name _____ **First** _____ **Middle** _____

Mailing / Physical Address _____ SSN _____

City _____ **State** _____ **Zip Code** _____

Home Phone(____)_____ **Cell Phone** (____)_____ **Work Phone**(____)_____

Date of Birth_____ **Gender:** Male Female **Marital Status:** S M D W **Email address** _____

Patient Employer: _____ **Employer Phone #:** (____)_____

Have you had home health or physical therapy this year? ( ) Y ( ) N **If so, where?** _____

POLICY HOLDER INFORMATION:

Name:_____ **Date of Birth:**_____ **Relationship to Patient:**_____

EMERGENCY CONTACT:

Name: _____ **Relationship:**_____

Home Phone(____)_____ **Cell Phone** (____)_____ **Work Phone**(____)_____

Treatment Consent & Authorization

Ambulatory Care Authorization

I, _____(patient or responsible party), hereby voluntarily authorize Moreau Physical Therapy to perform outpatient evaluation(s) and/or procedure(s) and to administer such outpatient therapy treatment(s) that in the opinion of the physician and consulting allied health provider is/are necessary or appropriate. It has been explained to me that medical treatment/therapy is not an exact science and no guarantee has been made as to the result of any treatment or care administered.

Patient's Signature_____ Date _____/_____/_____

Other/Responsible Party's Signature_____ Date_____/_____/_____

Reason patient cannot sign_____

Authorization to Release Information

I, the undersigned, hereby authorize Moreau Physical Therapy to release medical record information by means of telephone, reproduction, or facsimile transmission, relative to any outpatient therapy, treatment(s), or evaluation(s) to referring physician for status of treatment, family physician providing follow-up care, third party payer(s) to substantiate medical necessity and charge verification, and/or case manager(s) for determining medical necessity or utilization review.

This authorization shall be valid during the course of treatment and shall expire 365 days after discharge.

Patient's Signature_____ Date _____/_____/_____

Other/Responsible Party's Signature_____ Date_____/_____/_____

Reason patient cannot sign:_____

MOREAU PHYSICAL THERAPY - MEDICAL HISTORY

Patient Last name_____ **First**_____ **Middle**_____

Condition related to: ( ) Employment ( ) Auto Accident ( ) Other _____

Date condition/injury began: _____ **Body Site of Condition/Injury:** _____ **Date of Surgery:** _____

Currently working? ___ Yes ___No If Yes, please give your your occupation and describe demands: _____

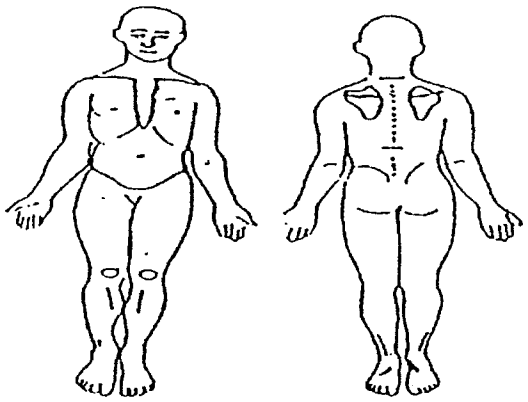
_____

_____

Pain Scale: It is important that we have a measure of your pain. Please rate the level of your pain on a scale of 1-10

1 2 3 4 5 6 7 8 9 10

Mild Moderate Extreme



Which of these words describes your pain? (Check all that apply)

___Sharp ___Dull ___Burning

___Aching ___Tingling ___Numb

___Constant ___Variable ___Radiating (moves)

On the models to the left, please shade the area of your body where your pain is present.

Are there any positions or activities that make your pain worse? _____

Are there any positions or activities that lessen your pain? _____

Medical Conditions (circle Yes or No)

Allergies	Yes	No		Leg Injury / Surgery	Yes	No
Anemia	Yes	No		Lung Disease	Yes	No
Back Injury/Surgery	Yes	No		Nausea / Vomiting	Yes	No
Blood Clot	Yes	No		Neck Injury / Surgery	Yes	No
Broken Bones – List:	Yes	No		Numbness / Tingling	Yes	No
Cancer or Chemotherapy Radiation	Yes	No		Osteoarthritis	Yes	No
Chest Pains	Yes	No		Osteoporosis	Yes	No
Coronary Heart Disease	Yes	No		Pacemaker	Yes	No
Diabetes	Yes	No		Pins / Metal Implants	Yes	No
Dizziness / Vertigo	Yes	No		Pregnant	Yes	No
Elbow / Hand Injury	Yes	No		Respiratory Problems	Yes	No
Fibromyalgia	Yes	No		Rheumatoid Arthritis	Yes	No
Fractures	Yes	No		Seizures – Type:	Yes	No
Headaches	Yes	No		Shoulder Injury / Surgery	Yes	No
Heart Attack / Surgery	Yes	No		Shortness of Breath	Yes	No
Hernia	Yes	No		Smoker	Yes	No
High Blood Pressure	Yes	No		Stroke	Yes	No
Hip Injury / Surgery	Yes	No		Vision or Hearing Problems	Yes	No
History of Falling	Yes	No		Weakness	Yes	No
Incontinence	Yes	No		Weight Loss	Yes	No
Increased pain at night	Yes	No		Recent Procedures	Yes	No
Infectious Disease	Yes	No		Recent Injections	Yes	No
Joint Replacement	Yes	No		Restrictions with Walking / Exercising	Yes	No
Kidney / Urinary Tract Disease	Yes	No				
Knee Injury / Surgery	Yes	No				

List any medications and the reason you are taking: _____

_____ **THERAPIST INITIALS:** _____

MOREAU
PHYSICAL THERAPY

Pediatric Therapy Policies and Procedures

Welcome to the Moreau Physical Therapy Pediatric Therapy Clinic. We are proud to have the opportunity to serve you and are committed to providing excellence in care.

Our policies and procedures have been developed to ensure that we provide the best experience when it comes to the care of your child and allows us to provide the exceptional service.

Clinical Environment

Our clinic consists of open gym spaces and more private treatment rooms to accommodate all of the needs of the patients. We are able to provide therapy in different environments to provide the best setting for different activities and different needs of individual patients. Our therapists are able to work privately or in close proximity to deliver the highest level of care.

We ask that only patients enter the clinical area unless a therapist asks a parent to be present for the treatment session or any other times in the clinic. We ask parents and caregivers to remain in the waiting room during the child's treatment session. If parents or caregivers would like to leave the clinic during the session, please speak with your child's therapist for prior approval. If you are late to return and pick up your child there will be a $1.00 per minute fee applied and this late fee is due at the time you arrive to pick up your child.

When the session is complete, your child's therapist has allotted time to review the therapy session with you. If you would like to observe any portion of the therapy session this can be coordinated with the therapist. Appointments for parents that wish to meet with the therapists for extended periods (10 minutes or greater) can be made at a separate time.

Payment for services

We are committed to your treatment being successful. Please understand that payment of your bill is considered as part of your treatment. All patients must complete our Information and Insurance form before seeing the therapist.

Initials _____

The part of the bill that you owe is always required at the time of service. We do not send invoices out for your co-pays, deductibles, or the part your insurance does not pay. **FULL PAYMENT IS DUE AT TIME OF SERVICE.**

We make it easy to collect payment at the time of service. You may choose to pay with cash, check or credit card. If you have a financial hardship, a payment plan may be arranged.
If you are uninsured, all fees are required at the time of service.

Insurance

Moreau Physical Therapy verifies your insurance benefits and files your claims as a service to you. **Patients should also contact their insurance provider to ensure they understand their insurance coverage and benefits.**

Payment towards deductibles, co-payment and co-insurance is due in full at the completion of each therapy visit.

Cancellation/No Show policy

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $25. This fee is not billable to your insurance and must be paid before attending your next therapy session. Please help us serve you better by keeping scheduled appointments.

If more than 2 cancellations are made during the month, a $25 cancellation fee will be charged regardless of cancelling on time.

If 2 consecutive appointments are missed in a row without contacting our office to reschedule therapy, services will be placed on hold. You will then be required to reapply for therapy and will be added to the waiting list to begin therapy. This policy is to ensure that we are able to utilize our available appointments for those patients who are compliant to get the most out of their therapy.

If your child is scheduled for more than one therapy discipline in a day and they do not attend both sessions the Cancellation/No Show policy will still apply for the missed visit.

Moreau Physical Therapy strives to provide excellence in therapy services and we staff our clinic to provide the highest level of care. Compliance with visits ensures that we will be able to remain providing care at a high level to our patients. Non-compliance with visits negatively impacts your child's ability to progress and will also limit other children from receiving the therapy they need. Please make every effort to be on time and limit missed appointments.

I have read and agree to the attached Pediatric Therapy Policies and Procedures:

Signature:_____ **Date:**_____

I understand that, under the Healthcare Portability and Accountability Act of 1996 (HIPPA), I have certain rights of privacy regarding my protected health information. I understand that this information can and will be used to:

- Contact, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of uses and disclosures on my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

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

Patient Name: _____

Signature: _____ Date: _____

Relationship to patient: _____

MOREAU
PHYSICAL THERAPY

Patient Easy Pay Consent

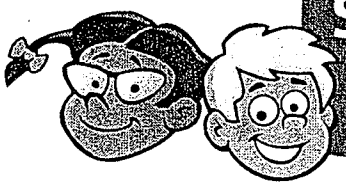
I authorize Moreau Physical Therapy to charge my credit card/debit card for the balance of charges not paid by my insurance for therapy services.

☐ Monthly: will be drafted on the 1st or 15th of the month. (Please note if the 1st or the 15th of the month is a holiday or weekend, then your account will be drafted on the following business day.)

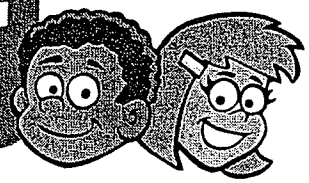
I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

Cardholder Signature _____ Date _____

Patient Name			
Cardholder Name			
Cardholder Address			
City		State	Zip
Credit Card Number ☐ Visa ☐ MasterCard ☐ Check Card ☐ Discover ☐ Other			Exp. Date



SPEECH-LANGUAGE-HEARING CASE HISTORY FORM



Identifying and Family Information:

Child's Name:_____ Birthdate:_____ Sex: ☐ M ☐ F
Father's Name:_____ Daytime Phone:_____
Address:_____ Cell Phone:_____
_____ E-mail:_____
_____

Mother's Name:_____ Daytime Phone:_____
Address:_____ Cell Phone:_____
_____ E-mail:_____
_____

Doctor's Name:_____ Doctor's Phone:_____

Child lives with (check one):

☐ Birth Parents ☐ Foster Parents ☐ One Parent
☐ Adoptive Parents ☐ Parent and Step-Parent ☐ Other _____

Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems

Child's race/ethnic group:

☐ Caucasian, Non-Hispanic ☐ Hispanic ☐ African-American
☐ Native American ☐ Asian or Pacific Islander ☐ Other _____

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one?_____
Does the child speak the language? ☐ Yes ☐ No
Does the child understand the language? ☐ Yes ☐ No
Who speaks the language? _____
Which language does the child prefer to speak at home? _____

Speech-Language-Hearing

Do you feel your child has a speech problem? ☐ Yes ☐ No

If yes, please describe. _____

_____

_____

Do you feel your child has a hearing problem? ☐ Yes ☐ No

If yes, please describe. _____

_____

_____

Has he/she ever had a speech evaluation/screening? ☐ Yes ☐ No

If yes, where and when? _____

What were you told? _____

_____

_____

Has he/she ever had a hearing evaluation/screening? ☐ Yes ☐ No

If yes, where and when? _____

What were you told? _____

_____

_____

Has your child ever had speech therapy? ☐ Yes ☐ No

If yes, where and when? _____

What was he/she working on? _____

_____

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? ☐ Yes ☐ No

If yes, please describe. _____

_____

_____

_____

Is your child aware of, or frustrated by, any speech/language difficulties? _____

_____

What do you see as your child's most difficult problem in the home? _____

_____

What do you see as your child's most difficult problem in school? _____

_____

Birth History

Was there anything unusual about the pregnancy or birth? ☐ Yes ☐ No

If yes, please describe. _____

_____

_____

How old was the mother when the child was born? _____

Was the mother sick during the pregnancy? ☐ Yes ☐ No

If yes, please describe. _____

_____

How many months was the pregnancy?_____

Did the child go home with his/her mother from the hospital? ☐ Yes ☐ No

If child stayed at the hospital, please describe why and how long. _____

_____

_____

Medical History

Has your child had any of the following?

- ☐ adenoidectomy
- ☐ allergies
- ☐ breathing difficulties
- ☐ chicken pox
- ☐ colds
- ☐ ear infections
  How often?_____
- ☐ ear tubes
- ☐ encephalitis
- ☐ flu
- ☐ head injury
- ☐ high fevers
- ☐ measles
- ☐ meningitis
- ☐ mumps
- ☐ scarlet fever
- ☐ seizures
- ☐ sinusitis
- ☐ sleeping difficulties
- ☐ thumb/finger sucking habit
- ☐ tonsillectomy
- ☐ tonsillitis
- ☐ vision problems

Other serious injury/surgery: _____

Is your child currently (or recently) under a physician's care? ☐ Yes ☐ No

If yes, why?_____

_____

Please list any medications your child takes regularly: _____

_____

_____

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

_____ sat alone
_____ babbled
_____ put two words together
_____ walked
_____ grasped crayon/pencil
_____ said first words
_____ spoke in short sentences
_____ toilet trained

Does your child...

- ☐ choke on food or liquids?
- ☐ currently put toys/objects in his/her mouth?
- ☐ brush his/her teeth and/or allow brushing?

Current Speech-Language-Hearing

Does your child...

- ☐ repeat sounds, words or phrases over and over?
- ☐ understand what you are saying?
- ☐ retrieve/point to common objects upon request (ball, cup, shoe)?
- ☐ follow simple directions ("Shut the door" or "Get your shoes")?
- ☐ respond correctly to yes/no questions?
- ☐ respond correctly to who/what/where/when/why questions?

Your child currently communicates using...

- ☐ body language.
- ☐ sounds (vowels, grunting).
- ☐ words (shoe, doggy, up).
- ☐ 2 to 4 word sentences.
- ☐ sentences longer than four words.
- ☐ other _____.

Behavioral Characteristics:

- ☐ cooperative
- ☐ attentive
- ☐ willing to try new activities
- ☐ plays alone for reasonable length of time
- ☐ separation difficulties
- ☐ easily frustrated/impulsive
- ☐ stubborn
- ☐ restless
- ☐ poor eye contact
- ☐ easily distracted/short attention
- ☐ destructive/aggressive
- ☐ withdrawn
- ☐ inappropriate behavior
- ☐ self-abusive behavior

School History

If your child is in school, please answer the following:

Name of school and grade in school: _____

Teacher's name: _____

Has your child repeated a grade? _____

What are your child's strengths and/or best subjects? _____

Is your child having difficulty with any subjects? _____

Is your child receiving help in any subjects? _____

Additional Comments