New Patient Registration Form

General Information

Patient's Full Name: _____ **Today's Date**: _____

***Preferred Name*:** _____ **Date of Birth:** _____/_____/_____ **Sex:** ☐Male ☐Female

Home Address: _____ **City**:_____ **State**:_____ **Zip**:_____

Pediatrician: _____ **Reason for referral/visit:** _____

Family/Guardian Information

(1) Parent//Guardian: _____ Date of Birth: _____/_____/_____

Cell Phone: _____ Email: _____

Place of Employment: _____ Phone Number: _____

(2) Parent/Guardian: _____ Date of Birth: _____/_____/_____

Cell Phone: _____ Email: _____

Place of Employment: _____ Phone Number: _____

Child lives with: ☐ Both Parents/Guardians ☐ Parent/Guardian 1 ☐ Parent/Guardian 2 ☐ My child is in the foster system ☐ Other _____

Siblings: ☐Yes ☐No If yes, names/ages?_____

Insurance Details

Primary Insurance: _____ Policy #: _____ Group #: _____

Policyholder/Guarantor : _____ Relationship to Patient: _____ Date of Birth: _____/____/_____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Policyholder/Guarantor : _____ Relationship to Patient: _____ Date of Birth: _____/____/_____

MUST PROVIDE INSURANCE CARD AT TIME OF SERVICE – DIGITAL COPIES ACCEPTABLE

Other Pertinent Information

Primary Language spoken in the home: _____ Other languages spoken at home: ☐Yes ☐No If yes, what?_____

Who lives in the home with the child? ☐Mom ☐Dad ☐Siblings – how many? _____ ☐Grandparents ☐Other relatives _____

(If under 3 years old) Is your child currently enrolled in Babies Can't Wait (BCW)? ☐Yes ☐No * ***If yes, must provide a finalized copy of IFSP***

(If 3 years or older) Does your child have a current Individualized Education Plan (IEP)? ☐Yes ☐No * ***If yes, must provide a finalized copy of IEP***

Is your child **currently** receiving any other therapies ☐Yes ☐No If yes, where?_____

Has your child been evaluated by another therapist/practice in the last six months? ☐Yes ☐No If yes, where?_____

Is your child currently enrolled in school? ☐Yes ☐No If yes, please provide school and grade _____

What activities does your child enjoy? _____ What activities upset your child? _____

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Medical History

Birth History: ☐Full-term (>37 weeks) ☐Premature ____weeks Complications during pregnancy/delivery? _____

Developmental Milestones: (answer in months)

(PT) Held up head ____ Rolled over ____ Sat alone ____ Crawl ____ Stood alone _____ Walk ____
(ST) Smiles ____ Babbles ____ First words _____ Joining words _____
(OT) Reach for objects _____ Finger Feed ____ Spoon-feeds self ____Toilet-trained _____
(Feeding) Bottle Type/Nipple _____ Transition to cup/straw _____ Purees introduced ____ Table foods introduced _____

Please describe any concerns about your child's development: _____

Other Concerns/Medical Conditions:

☐Seizures - Type: _____ ☐ Cardiac (heart) condition - Type: _____ ☐Reflux – Medication?_____

☐Diabetes- Type: _____ ☐ Frequent ear infections – PE Tubes, date?_____

☐ Asthma – Severity:_____ ☐ Difficulty sleeping – Describe child's sleeping schedule: _____

☐ Medical Equipment (i.e. stander, wheelchair, braces/AFOs, etc.) – Type? _____

Hearing Tested ☐Yes ☐No If yes, date of last hearing test: _____ Within Normal Limits: ☐Yes ☐No Aids ☐Yes ☐No

Must provide copy of hearing screening results if being evaluated for speech therapy and insurance is GA Medicaid or services will **not** be approved*

Vision Tested ☐Yes ☐No If yes, date of last vision test: _____ Within Normal Limits: ☐Yes ☐No Glasses ☐Yes ☐No

Allergies ☐Food ☐Medication ☐Environmental ☐Seasonal ☐Other _____

Please list (explain reaction): _____

Illnesses, diagnoses, or other conditions not addressed above (list – further explanation to therapist as needed): _____

_____

Hospitalizations, surgeries (list with dates – further explanation to therapist as needed): _____

_____

Physicians/Specialists on your child's care team

Name	Specialty	Location

Medications (including both prescription and over-the-counter)

Medication Name	Dosage	How Often Taken?	Reason for Medication

Feeding (if applicable to evaluation/concerns)

☐ Tongue/Lip Tie – Repair date _____ ☐ Difficulty drinking from bottle, breast or cup – Type of bottle/cup used _____

☐ Coughing/choking on liquids/foods ☐ History of Aspiration – Swallow study date _____

☐Food/liquid aversion/refusal (picky eater) ☐ Difficulty transitioning from bottle to purees ☐Difficulty chewing/oral motor concerns

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Assignment of Benefits/Privacy Practices/Treatment Consent

Assignment of Benefits:

I authorize release of medical information for _____ (*child's name*) necessary for billing purposes and assign the payment of medical benefits be made directly to Coastal Pediatric Therapies and its affiliate (J&K Therapy, Inc. – Jane Yaklin). I understand that I am responsible for any balance in excess of the benefits provided by my policy. I understand that by initialing below and accepting treatment I agree to abide by these terms. I understand that it is my responsibility to be aware of precertification requirements and limitations of providers. **Initial:** _____

Receipt of Notice of Privacy Practices:

I, _____ (*parent's name*) certify that I am the parent/legal guardian of the child named above and hereby acknowledge receipt of a detailed copy of Coastal Pediatric Therapies' Notice of Privacy Practices, which outlines in detail how medical information may be used and disclosed as well as how I might obtain an explanation as to what entities my information has been released. I have read and understand Coastal Pediatric Therapies' Notice of Privacy Practices and may request a copy by mail or in person at any time. **Initial:** _____

Consent for Treatment

I, knowing that _____ (*child's name*) has a diagnosis requiring occupational, physical, and/or speech therapy, voluntarily consent to such care deemed beneficial by the clinician's professional judgment for the aforementioned child. I am aware that the practice of occupational/physical/speech therapy is not an exact science and I acknowledge that no guarantee has been made to me as to the effect of occupational/physical/speech therapy treatment for my child. **Initial:** _____

Authorization to Release Medical Information:

Additionally, I authorize Coastal Pediatric Therapies, LLC and its said affiliate to obtain or release any medical information necessary to provide medical services to me and/or to process insurance claims. In addition, I authorize Coastal Pediatric Therapies to release any of my medical information that is required for any health care related utilization review, quality assurance activities or other healthcare operations. I understand medical information to be disclosed may include history, evaluation reports, consultation reports, progress notes, and discharge summaries.

I understand this consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Excluding revocation, this consent shall remain in effect as long as my child is a patient of Coastal Pediatric Therapies and/or its said affiliates. A photocopy of this consent shall be considered as effective and valid as the original. I understand I have the right to receive a copy of this consent.

Below is a list of names of any family members, friends, and significant others who may receive information concerning my child's therapy:

Name	Relationship

Financial Policy

Private Insurance: We will file your private insurance for you if you provide all the required information at the time services are rendered and agree to grant assignment of benefits to the treating therapist(s). We will make every effort to gain pre-certification where needed; however, it remains your responsibility to make sure the pre-certification has been approved. Some insurance companies have contracts that reduce, limit, or exclude payments to therapists who are not in network. It is your responsibility to know if your insurance has such contracts and with whom. You will receive a monthly statement of your balance. Any balances for charges that are not covered are your responsibility and you will be expected to continue making payments until the balance is paid in full. In the event your insurance company does not make payment within 45 days of our billing, you may at our discretion be expected to begin payment on the account. Please note all copays are due at the time of service.

Medicaid, and any related Care Management Organization: If your child receives services through Medicaid, Deeming Waiver or any CMO you must provide a Medicaid card. Please be reminded Medicaid provides a limited number of treatments of each therapy per month. If you have given any other agency/school permission to bill Medicaid, it may affect our ability to receive payment and could result in dismissal from treatment.

Babies Can't Wait: If you're child has participated in a Babies Can't Wait evaluation previously, it is your responsibility to let the front office and/or your therapist know. You will be responsible for any charges incurred if your evaluation is not approved.

Self-Pay: We will work with you to establish a reasonable payment plan so that lack of insurance coverage does not prevent your child from receiving the therapy he/she needs; however, you will be held accountable for your financial agreement.

Collection Proceedings: I hereby agree that if I fail to make monthly payments once notified of my balance, rebilling charges may be added to my bill for each monthly statement I fail to respond with a payment. If Coastal Pediatric Therapies' management deems it necessary to place my account with a collection agency, their collection fees may be added to my balance as well.

Responsible Party Signature: _____ Relationship: _____ Date: _____

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Student Observation/Internship Release

Patient Name: _____ Date:_____

COASTAL PEDIATRIC THERAPIES, LLC participates in clinical education programs with area colleges and universities to give students engaged in a course of study related to therapeutic practices experience in clinical practice. Your speech-language pathologist, occupational therapist, and/or physical therapist has agreed to permit these students to observe and participate in patient care activities, including, where appropriate, providing therapy service to patients under the clinician's direct supervision (e.g., in an approved clinical practicum).

By signing below, you agree to permit students shadowing/working with your child's therapist to observe your therapy sessions, including, where appropriate, providing direct treatment under your clinician's direct supervision. Participation is voluntary and you are not required to sign this consent form in order to receive treatment. You have the opportunity to refuse to give such consent and you may withdraw your consent at any time during your appointment.

_____(initial) I hereby give my consent for student observations/internships during my therapy sessions at COASTAL PEDIATRIC THERAPIES, LLC. I understand that at any time I can revoke my consent for participation.

OR

_____(initial) I **decline** to give consent to student observations/internships during my therapy sessions at COASTAL PEDIATRIC THERAPIES, LLC. I understand that declining will not impact the quality of therapy services that my child receives.

Signature of parent, guardian, or legal representative of child: _____

Printed name of parent, guardian, or legal representative of child: _____

Date: _____

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Acknowledgment and Release for Photographs

The undersigned parent or guardian acknowledges that, during therapy sessions, **Coastal Pediatric Therapies and its said affiliate** may photograph and/or video and audio record _____ (patient's name). The images and recordings may be used for formulating treatment plans and objectives and assisting in professional education, teaching, and data collection. The images and recordings may be shared with other patients for the foregoing purposes. Under no circumstances will the Patient's personal identifying information be shared or disclosed.

_____
Initials

The undersigned hereby consents, on behalf of the Patient, to such photography and recordings for the uses and purposes described above.

_____
Initials

The undersigned *further* consents, on behalf of the patient, to **Coastal Pediatric Therapies' and its said affiliate** use of such photography and recordings for marketing or promotional purposes in **Coastal Pediatric Therapies' and its said affiliate** web and print marketing and grants **Coastal Pediatric Therapies and its said affiliate** and its successors and assigns permission to copyright, use, reproduce, and publish the images and recordings, without compensation.

Signature of parent, guardian, or legal representative of child: _____

Printed name of parent, guardian, or legal representative of child: _____

Date: _____

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Release for Appointment Reminders

I, _____ (parent's name), hereby authorize **Coastal Pediatric Therapies and its said affiliate** to send me an appointment reminder via email using the following information.

Email reminders may contain patient information such as, but not limited to, patient first name & clinic location.

☐ I would like to **only** receive an email reminder to the following address

Email Address: _____

☐ I would like to to receive text reminders as a forwarded message. By checking this box I understand I will have to provide my cell phone carrier information to Coastal Pediatric Therapies. Please note only the following carriers support this feature at this time (Verizon, T-Mobile, AT&T, Sprint)

Cell phone number: _____

Cell phone carrier: _____

Signature of parent, guardian, or legal representative of child: _____

Printed name of parent, guardian, or legal representative of child: _____

Date: _____

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Attendance/Cancellation Policy

We strive to provide the most consistent and convenient care for all families. Simultaneously, we strive to make CPT the **best** place to work for our staff; therefore, we all like to stay busy and have full schedules! When patients cancel or "no show," this creates schedule disruptions resulting in unfilled appointment times.

We are more than happy to work with you as we know things come up; however, we have so many children needing therapy that this policy is proving to be the only way to accommodate the needs of everyone.

If you do not show up (give us no prior notice) for your appointment, you **no longer** have a "standing appointment" and must be in touch with our office weekly to be scheduled. ____**(initial)**

If you cancel more than 25% of your scheduled appointments in a month time, you will **no longer** have a "standing appointment" and must be in touch with our office *weekly* to be scheduled. ____**(initial)**

We appreciate your understanding and dedication to your child's progress!

I understand my appointments will be directly affected by my attendance record in therapy per this policy.

Signature of parent, guardian, or legal representative of child: _____

Printed name of parent, guardian, or legal representative of child: _____

Date: _____

Thank you,

Our Coastal Pediatric Therapies' Team

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