Pediatric Registration Packet
Physical/Occupational Therapy

Scan No. _____

Initials _______

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial)		Marital Status: M S W D	
		Circle One: Female or Male	
Address		Social Security Number	Date of Birth
City State Zip Code		Email Address	
Best Contact Number	Emergency Contact Name/Number		

What type of appointment reminder do you prefer? □ Email □ Phone call

What format do you prefer for your rehab documents and home exercise program? □ Email □ Printed handouts

Are you receiving any nursing, aide, or therapy services in your home? □ Yes □ No *(If yes, notify the Front Office)*

For Medicare beneficiaries, have you received therapy in this calendar year? □ Yes □ No

Is this a Workers' Comp injury? □ Yes □ No **Date of Injury:** ____________ **Adjustor:** __________________ **Employer:** ________________

INSURANCE INFORMATION

Primary:	**Secondary:**	**Tertiary:**
Policy/ID#:	**Policy/ID#:**	**Policy/ID#:**
Name of Policy Holder:	**Name of Policy Holder:**	**Name of Policy Holder:**
Relationship to Patient:	Relationship to Patient:	Relationship to Patient:
Date of Birth (Policy Holder):	Date of Birth (Policy Holder):	Date of Birth (Policy Holder):
SS# of Insured (Policy Holder):	SS# of Insured (Policy Holder):	SS# of Insured (Policy Holder):
Effective Date:	Effective Date:	Effective Date:
Group Number:	Group Number:	Group Number:

Below is an estimation of benefits. It may be subject to change based on your insurance.

YTD Deductible $:	YTD Deductible $:	YTD Deductible $:
YTD Deductible Met $:	YTD Deductible Met $:	YTD Deductible Met $:
Co-Pay Per Visit $:	Co-Pay Per Visit $:	Co-Pay Per Visit $:
Estimated Co-Insurance Per Visit $:	Estimated Co-Insurance Per Visit $:	Estimated Co-Insurance Per Visit $:
Insurance Coverage %:	Insurance Coverage %:	Insurance Coverage %:
Patient's %:	Patient's %:	Patient's %:
Total Visits Authorized: Visits Available: Auth End Date _____________ $ Limit__________________ **Are we in network?** □ **Yes** □ **No**	Total Visits Authorized: Visits Available: Auth End Date _____________ $ Limit__________________ **Are we in network?** □ **Yes** □ **No**	Total Visits Authorized: Visits Available: Auth End Date _____________ $ Limit__________________ **Are we in network?** □ **Yes** □ **No**

Dear Parent/Guardian,

For insurance to cover your child's treatment here, the following information is required.

Is your child receiving special services or therapy treatment from the local independent school district? □ **Yes** □ **No**

If **YES**, please provide a copy of your child's current IEP/ARD if receiving any services from your school district.
If **NO**, please complete the following statement:

To Whom It May Concern:

I am the parent/guardian of ____.
(Please Print Child's Name)

My Child is NOT receiving special services or therapy treatment from the local independent school district.

_________________________________	_________________________________	______________
Parent/Guardian Signature	Parent/Guardian Printed Name	Date

For our emergency records, please complete the following:

MEDICAL RELEASE

I, ________________________________, Parent or Legal Guardian of ________________________________
In my absence hereby authorize any Medical or Surgical treatment which may be necessary in an emergency situation while attending Integrity Rehab, for the wellbeing of the above mentioned minor. I agree to hold Integrity Rehab, the physician, and/or the hospital treating the above mentioned minor, harmless.

EMERGENCY MEDICAL INFORMATION

Drugs/Allergies/Special Medication Needs____

Chronic Diseases/Other Health Problems____

Integrity REHAB

Pediatric Medical History

Patient Name: ______________________________

Date of Birth: ______________________________

Name of your Primary Care Physician: ______________________________ **Location:** ____________________

Indicate person/s child lives with: ___Father ___Mother ___Step-father ___Step-mother ___Other:______________

Check reason/s seeking therapy services:

_____Motor/Developmental Delay ____Torticollis ____Weakness _____Pain ____Other:____________________

Describe your child's problem:____

When did you first notice the problem? ____

Does anyone else in the family have a motor, coordination, developmental problem? ____Yes ____No

If **YES**, please **Describe:** ____

Please list previous EVALUATIONS and results (Hearing, Speech and Language, Behavior, Sensory/Motor Skills) and other DIAGNOSTIC TESTS (X-ray, MRI, CT Scan, EMG Study, Genetic Testing) for current problem

DATE LOCATION EVAULATIONS/DIAGNOSITIC TESTS RESULTS

____

____

Check other professionals who are currently treating your child. ___ABA ___Nutrition ___Speech Therapy ___Psychology/Psychiatry ___Occupational Therapy ___School Therapy ___Other: ______________

Check the following CONDITIONS your child has been diagnosed with or is having current symptoms.

___ADD/ADHD
___ADHD
___Allergies
___Anemia
___Asthma
___Autism
___Birth Injury
___Breathing Problem
___Cancer
___Cerebral Palsy
___Depression
___Down's Syndrome
___Drooling
___Ear Infections
___Ear Tubes
___Emphysema/Bronchitis
___Epilepsy
___Fevers – high/prolonged
___Grinding Teeth
___Head Injury
___Heart Problem
___Hearing Loss
___Intellectual Disability-ID
___Kidney Disease
___Multiple Sclerosis
___Reflux
___Rheumatoid Arthritis
___Ringing in ears/Dizziness
___Seizures
___Spina Bifida
___Stroke
___Tuberculosis
___Other: ____________

Please list any hospitalizations, injuries, and other chronic or severe illness your child has experienced:

DATE HOSPITALIZATIONS/INJURIES/SURGERIES/OTHER REASON

____

____

Please list all PRESCRIPTION (Rx) and OVER THE COUNTER (OTC) medications your child is currently taking (Include all injectable, oral, rectal, and topical medications):

____

CONSENT FOR TREATMENT: I hereby authorize Integrity Rehab to provide therapy services to ____ that have been ordered by my (his/her) physician and are under the direct supervision of a licensed health care professional. I also understand that it is my (his/her) right to accept or refuse medical treatments.

AUTHORIZATION OF RELEASE OF INFORMATION AND PAYMENT: In applying for payment under Title XVIII or Title XIX of the Social Security Act, or other third party payer sources, I certify that the information given by me or a person authorized by me is correct. This authorization and request shall begin on _______________ (TODAY'S DATE), and continue until such time that it is revoked by me, my legal representative, physician or this clinic. I also agree if there are any changes to the billing information (i.e., change in insurance company or policy, becoming ineligible or eligible for Medicare and/or Medicaid, etc.) that I will notify the clinic immediately. If I fail to report changes with my insurance to Integrity Rehab's billing department I will be financially liable/responsible. I understand that I am financially responsible for all charges that my insurance company does not pay. I authorize the release of any information necessary in order to process any billing.

RELEASE OF INFORMATION/CONFIDENTIALITY: I hereby authorize any physician, hospital/medical facility, laboratory, or other health care provider to release to Integrity Rehab any information requested by them for the purpose of continuity of care. I also authorize Integrity Rehab to release any of my (his/her) health care information from them to other health care providers involved in my (his/her) care, or any facility where I (he/she) may be admitted for the purpose of continuity of care. A written consent from patient or legal representative is required to release medical information to persons not otherwise authorized by law (federal and state). **For pediatric patients I agree to the Pediatric Speech Therapy Procedures.**

NOTICE OF NON-DISCRIMINATION: Integrity Rehab does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, or national origin, or on the basis of disability or age.

GRIEVANCE/COMPLAINT PROCEDURE: Should I have a grievance or complaint; I understand that every attempt will be made to rectify the situation without fear of reprisal. I may contact the Clinic Director, Compliance Officer, or Administrator by calling (254) 699-3933 or emailing Compliance@IntegrityRehab.net. If the grievance or complaint is not resolved to my satisfaction, I may follow the printed "Consumer Information Notices" in the Reception area.

PHOTOGRAPHY: I **DO** ___ **DO NOT** ___ authorize Integrity Rehab to photograph, videotape, or audio record me (him/her) for medical education or reasons related to treatment and/or promotion of Integrity Rehab operations. Patient's name will not be used.

INFORMATION RECEIVED: I have reviewed a laminated copy of the following information to **read and understand:** 1) **Notice of Privacy Practices**, 2**) Cancellation and No-Show Policy,** and 3) **General Health** Guidelines**. I may request a copy to take home with me**. For **pediatric patients**, in addition to the preceding information, I have **reviewed** a laminated copy of **Pediatric Speech Therapy Procedures**.

In addition, the following NEW PATIENT INFORMATION is available upon request:

- Abuse, Neglect, and Exploitation
- Advance Directives
- Cell Phone Policy
- Children Policy
- Civil Rights
- Disaster/Emergency
- Employee Drug Testing
- Rights of the Elderly

I acknowledge that the information above has been provided to me or is accessible to me in my primary language, or via an interpreter. I certify that the information I have provided in this registration packet is accurate and complete.

____

Patient signature and date

____

Authorized agent signature and date **Relationship to patient**