Manual Edge
PHYSIOTHERAPY
Hands-On Healing

Patient Registration Form - Pediatric

Patient Name:	Date of birth:
Name Patient Goes By:	
Address, City, State, Zip:	
Parent/Guardian Information	
1st Parent/Guardian name:	Contact number:
Address if different form above:	
2nd Parent /Guardian name:	Contact number:
Address if different from above	

Home Phone:	Work phone:	Appointment Reminder Method
Cell Phone:		☐ Home Phone ☐ Cell Phone
Email address:		☐ Work Phone ☐ Email

2nd Contact name/address:	
2nd contact phone:	Relation:
Pediatrician/Physician:	Referred by:

INSURANCE INFORMATION Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible to provide their most current insurance information.

Primary Insurance:		Secondary Insurance:	
Group #	Policy #	Group #	Policy #
Insured Information:		Insured Information:	

Consent to Treat/Assignment of Benefits/Acknowledgements

I hereby authorize and consent to treatment/services for myself, or on the behalf of the above-named patient performed by the staff at Manual Edge Physiotherapy, LLC and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.

I assign payment for these services directly to Manual Edge Physiotherapy, LLC. I authorize the filing of claims to my insurance plan and authorize Manual Edge Physiotherapy, LLC to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.

In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believed were covered services, resulting in my responsibility for paying for these services.

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.

_____ _____

Signature of Patient/Guardian Date

_____

Print name and relationship to the patient

Patient name:

Authorization for Communication

By providing my above contact information and signing below, I consent and authorize Manual Edge Physiotherapy, LLC and its related entities, agents, contractors, including but not limited to scheduling, billing, marketing and other departments to use automated telephone dialing systems, SMS text messaging, and electronic mail to (1) provide messages (including prerecorded messages or text messages) to me about appointment reminders, patient surveys, my account, payment due dates, missed payments, information for or related to medical goods and/or therapy services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that providing a telephone number and/or email address is not a condition of receiving medical services.

I also understand that I may revoke my consent to contact at any time by directly contacting Manual Edge Physiotherapy, LLC or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Manual Edge Physiotherapy, LLC immediately of any change in telephone number or email address.

Patient/Guardian Signature: Date:

Release of Information

I hereby authorize Manual Edge Physiotherapy, LLC to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis and/or billing and payment for services rendered on my behalf to the person(s) listed below.

Name (print)	Relationship	Phone number
Name (print)	Relationship	Phone number
Name (print)	Relationship	Phone number

Patient/Guardian Signature: Date:

Financial Policy

Patient Name:

Cancellation/No show

Successful therapy is dependent on a strong working relationship between the patient and the therapist. Maximum progress and success are made when the patient is an active participant in their home exercise program and attends all appointments.

Manual Edge Physiotherapy, LLC requires 24-hour notice for ALL cancellations. There may be a $75.00 fee assessed which is not covered by insurance and would be an out-of-pocket expense for cancellations without proper notice.

If a cancellation is unavoidable, we do ask that you give us as much notice as possible so we may offer that appointment time to another patient.

- If you arrive later than 15 minutes after your scheduled appointment time, we may ask you to reschedule.
- After more than one cancellation or no show, we require that you call the day of for an appointment.
- 2 "no show" appointments may result in discharge from therapy.

Payment for services is due at the time services are rendered

We will verify your benefits with your insurance carrier. However, this does not guarantee that they will cover the prescribed treatment. By signing below, you are acknowledging that you are responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance carrier and understand that you are fully responsible for any balance due for services rendered.

Patient/Guardian Signature: Date:

PEDIATRIC PATIENT HEALTH QUESTIONNAIRE

Patient name: Current Diagnosis:

What are the patient's pronouns? ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other:

Does the patient think of themselves as: ☐ Male ☐ Female ☐ Transgender
☐ Neither exclusively male nor female ☐ Additional gender category, please specify: ☐ Decline to Answer

What sex was originally listed on the patient's birth certificate? ☐ Male ☐ Female ☐ Decline to Answer
For billing purposes, it is helpful to know gender assigned at birth. There can be confusion when a patient legally changes their birth certificate to the gender they align with, but insurance companies' data is lagging behind.

Lives with both parents? ☐ Yes ☐ No If no, with whom does this child live most of the time?

Siblings - Name, ages, and any history of delays:

Is this child: ☐ Biological ☐ Adopted Height: Weight:

Please indicate – Length of pregnancy: Birth weight:

Notable circumstances during pregnancy, labor, deliver, and/or following birth:

List any precautions you would like for us to know.

Please list specialists/physicians seen, including dates, names, specialty.

List any special tests (x-ray, MRI, etc.) including dates.

Please list any known allergies (including medications, latex, etc.) below.

Has your child had a vision test/screening? ☐ Yes ☐ No Date: Results:

Please indicate if you child has had the following vaccinations.
MMR: ☐ Yes ☐ No **Hepatitis:** ☐ Yes ☐ No **Chickenpox:** ☐ Yes ☐ No

Please mark any of the following illnesses that are common conditions in your child – list approximate age out beside the condition listed.

Allergies	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	High Fever	☐ Yes ☐ No
Chickenpox	☐ Yes ☐ No	Measles	☐ Yes ☐ No
Colds	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Croup	☐ Yes ☐ No	Tonsillitis/Adenoids	☐ Yes ☐ No
Ear Infections	☐ Yes ☐ No	Other, please list	☐ Yes ☐ No

Please list current medications and for what condition (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.

Name	Dosage	Frequency	Condition

Surgery / Hospitalization, please include date and reason.

List any significant illnesses.

Patient Name:

Developmental History – please indicate at what age your child achieved the following developmental milestones.

Babbling		Sitting	
Crawling		Standing	
Combining Words		Toilet Training	
Single Words		Walking	

Describe general coordination:

Are there currently or have there been any feeding problems (i.e., sucking, swallowing, drooling, chewing, extreme picky eating, etc.)?
☐ Yes ☐ No Please explain.

Describe your child's current vocabulary.

How many words is he/she using? ☐ 1,000+ ☐ 100-1,000 ☐ 50-100 ☐ 25-50 ☐ 10-25 ☐ 10 or less

If nonverbal, how does he/she communicate?

Language spoken at home?

Describe social language skills.

Educational History

School: Grade:

Please indicate your child's school schedule (i.e., days, times, etc.)

Describe your child's school performance.

What if any special services do your child receive at school?

Previous Assessments and Therapies

Please list any developmental therapies or interventions your child has participated in or is currently participating in, include dates. (OT, PT, SLT, music therapy, counseling, etc.)

Social and Other Information

Interests/Hobbies.

Describe peer relations.

Describe your child's most concerning/challenging behaviors.

Does your child have any textures they like or dislike?

My child's fears are:

What works to motivate or reward your child?

What other information would you like for us to know about your child that would aid in their evaluation/treatment?

Prioritize your top 3 concerns you want to be sure we address in this evaluation and/or therapy?

1.

2.

3.

I certify the above information is correct to the best of my knowledge and will advise the therapist if there is any change in the information provided above.

Signature: _____ Date: _____

Clinician signature: _____ Date: _____