PROGRESSIVE pediatric therapy

West Palm Beach Clinic
5589 Okeechobee Blvd.
Suite 205
West Palm Beach FL 33417

Boca Raton Clinic
5458 Town Center Road
Suite 10
Boca Raton FL 33486

Phone: 561-376-2573 Fax: 561-218-4939 www.ppt4kids.com

Appointment Cancellation Policy

Your appointment time is important to you, your therapist and to others who are in need of our services.

If you cannot keep your appointment for any reason, please call us 24 hours prior to your appointment time. If you miss three appointments and/or cancel with less than 24 hours notice three times, your child will be discharged from our practice.

Please help us keep the scheduling of appointments fair for everyone. Thank you.

_____ _____
Signature Date

_____ _____
Printed Name Child's Name

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PERSONAL INFORMATION

Today's Date: _____

Child's name: _____ Date of Birth: _____

Diagnosis: _____ Male/Female: (M/F) _____

Race: American Indian/Asian/Black/Caucasian/Other/Decline:_____

Ethnicity: Hispanic/Non-Hispanic/Declined Language: _____

Parent/Guardian Name: _____

Relationship to Child: _____

Second Parent/Guardian Name (if applicable):_____

Relationship to Child:_____

Child Resides With:_____

Home Address: _____
Street and Apartment Number

_____
City State Zip Code

_____ _____ _____
Home Telephone Cell Phone #1 Name for Cell Phone #1

_____ _____
Cell Phone #2 Name for Cell Phone #2

_____ _____
Work Phone Name for Work Phone

Email: _____

Insurance Carrier: _____ Group #: _____

Insured Party: _____ Individual #: _____

Insured Party's DOB: _____

Insurance Phone Number: _____

Pediatrician: _____ Phone: _____

Other Specialist: _____ Phone: _____

Who Referred You?: _____ Phone:_____

Emergency Contact: _____ Phone: _____

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If insurance does not cover all of therapy services, I agree to pay bill in full amount within 30 days of service date. I understand payment is due at the time of service.

Parent/Guardian Signature: _____

Date:_____

PROGRESSIVE PEDIATRIC THERAPY PARENT INTAKE FORM

Date: _____ Child's Name: _____

Date of Birth: _____ Chronological age: _____ Adjusted age (for prematurity) _____

Did you receive Prenatal Care? Y/N Pregnancy Complications? Y/N; If yes, describe:

_____

_____

Delivery Complications? Y/N; If yes, describe: _____

_____

Delivery Type? Vaginal/C-Section (emergency)/C-Section (planned) Full Term? Y/N

If no, enter # weeks premature: _____ Birth Hospital: _____

Birth weight: _____lbs _____ ozs Post birth jaundice? Y/N Light treatment needed? Y/N

If yes, how many days? _____ IVH Grade: _____

NICU? Y/N Time in NICU: _____

NG Tube? Y/N G tube: Y/N Oxygen? Y/N Retinopathy? Y/N Apnea monitor? Y/N

Heart problems? Y/N Reflux? Y/N

Other complications?

_____

_____

Hearing Test Done? Y/N Date: _____ Hearing test type? _____ Results? _____

Vision Test Done? Y/N Date: _____ Results: _____

Other Comments: _____

Surgeries and hospitalizations: _____

_____

Family history for developmental delays? Learning disabilities? Speech Delays? _____

_____

Medications? _____

Allergies? _____

Ear Infections? Y/N How many? _____ PE Tubes? Y/N Date Inserted? _____

Other therapies? Y/N PT/OT/ST/DT/SI/ABA/Other If yes, frequency? _____

Breast Fed? Y/N Bottle fed Y/N If yes, Formula type: _____ __ oz's _____ every ____hours

Does your child use any of the following? Sippy cup: Y/N open cup: Y/N straw cup: Y/N

Spoon: Y/N Fork: Y/N finger feeds? Y/N

Does your child like all food textures and temperatures? Y/N If no, please explain: _____

_____

Does your child have feeding issues? If yes, please explain: _____

Please list feeding concerns, if any: _____

Child sleeps how many hours a night? ___ Sleeps through the night? Y/N Sleeps in crib? Y/N

Does your child nap? _____ How many/how long? _____

Does your child put self to sleep? Y/N

Please list any behavior concerns/issues: _____

_____

_____

_____

What is parent/guardian's main concern for child? _____

_____

_____

Child lives with (circle all that apply)

mother	father	sister(s)	brother(s)	grandmother
grandfather	aunt(s)	uncle(s)	cousin	other/explain

Child spends the day with/at: _____

Primary communication form: words pointing grunting pulling pushing sign language pictures

Number of words: _____

Primary household language: _____

Primary patient language: _____

Any other medical concerns or other concerns we should know about?

_____

_____

_____

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Health Care Consent

Patient Name: _____ Date of Birth: _____

CONSENT TO TREAT: I (parent or guardian), for the patient named above hereby consent to such medical treatment and diagnostic procedures as beneficial and appropriate for the patient's condition or illness based on the judgment of the physician(s), to be performed by the health care provider(s). I have had, and will continue to have, an opportunity to discuss treatment options with my health care provider(s), ask questions regarding such treatment options, and understand the options discussed.

RELEASE OF MEDICAL INFORMATION: I hereby authorize Progressive Pediatric Therapy, Inc. to release any and all pertinent information contained in my medical records (current and prior) for:
Treatment: Includes activities performed by health care practitioners in providing, coordinating, or managing care with third parties and consultations with other health care providers.
Payment: Includes activities involved in receiving payment for services rendered and any review of care for medical necessity, justification of charges, and pre-authorizations.

ASSIGNMENT OF BENEFITS: In consideration of services rendered, I hereby assign and authorize direct payment to Progressive Pediatric Therapy, Inc. of any insurance, health plan, or third party payor benefits otherwise payable to me or on my behalf (or on behalf of the patient) for these services.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____

Relationship to Patient: _____ Date: _____

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Credit Card Authorization Form

Patient Financial Responsibilities: DEDUCTIBLES, CO-PAYS, AND CO-INSURANCE'S ARE DUE IN FULL AT THE TIME OF SERVICE.

We require a credit card on file. Regardless if you choose to use this as your credit card for payment at time of service, it will automatically be charged for the balance of any outstanding amounts (including service charges, co-pays, and deductibles) that are not settled within 60 days of service.

Today's date: ____/____/____

Child's name: _____

I (please print name): _____ agree to the following:

Please check the one option you prefer:

☐ **I will pay at time of service.** If my health insurance does not cover my visits 100%, I will pay an estimated amount of the patient financial responsibility with each visit based on verification of my health insurance company's explanation of benefits provided. I understand that this is just an estimated amount and the actual amount due may be more or less than what is collected. Any overpayment will be refunded upon full processing of all claims.

☐ **Automatic Payment.** I understand my credit card will automatically be charged for any balance due for my child's therapy services. ***This payment method must be checked if services are not being provided in the clinic.*** Debit cards cannot be used to secure an account.

Credit Card Information:

Name as it appears on card:

_____

Type of Card: □ VISA □ MASTERCARD □ DISCOVER □ AMERICAN EXPRESS

Credit Card Number _____- _____- _____-_____ Expiration Date ____/____

Security Code BACK of Visa OR Master Card: (3 digits) _____

Security Code FRONT of Amex Card: (4 digits) _____

Credit Card Billing Address: Street: _____

City: _____State: _____ Zip Code: _____

Telephone: _____

Cardholder Signature: _____

Email Address (for receipts): _____

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PHOTOGRAPHY CONSENT FORM/RELEASE FOR MINOR CHILDREN (Under 18)

I, (print name) _____, parent or official guardian of (print child's name)_____ hereby grant permission to Progressive Pediatric Therapy to take and use photographs and/or digital images of my child for use in news releases and/or educational materials as follows: printed publications or materials, electronic publications, or website. I agree that my child's first name and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize use of these images without compensation to me. All negatives, prints, and/or digital reproductions shall be the property of Progressive Pediatric Therapy.

Parent Name (please print): _____

Parent Signature: _____

Date Signed: _____