Walker Physical Therapy & Wellness
Maximizing Every Child's Potential

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Patient Name:_____ Date of Birth:_____

Child SSN:_____Caregiver SSN:_____

Guardian(s):_____

Address:_____

Phone Number(s):_____

Emergency Contact: Please list who to call for an Emergency & whom has authority to or whom may care for child other than known guardian:
Name(s):_____
Phone:_____Relationship:_____

Patient History/Diagnosis/Primary Concern for having child evaluated?

_____

_____

_____

I,_____ hereby authorize Walker Physical Therapy & Wellness to send me appointment reminders via text/email or contact via phone call using information such as patient name, date and time of appointment.

Contact method regarding information about your child? Circle preferred method

Phone:_____(is text or phone call preferred?)
Email:_____

Past Medical History:

Birth Weight: _____Born at How Many Weeks?_____ Prematurity/NICU?_____

Has your child had:
Hearing checked?___Yes___No Date:_____ Results:_____
Vision checked?___Yes___ No Date:_____ Results:_____
Immunizations?_____Yes_____No Are They Up to Date?_____Yes_____N

Any Medical Diagnoses given:_____
Medications:_____
Allergies:_____

Any other pertinent health information that you feel therapist should know?

_____

_____

_____

All of the above information is true to my knowledge:

Guardian signature:_____**Date:** _____

Consent To Bill:

Initial_____I hereby authorize Walker Physical Therapy and Wellness to bill my insurance company direct reimbursement of therapy services rendered to my child. Unless otherwise noted, benefit payment will be assigned directly to Walker Physical Therapy and Wellness. I agree to let Walker Physical Therapy and Wellness release any medical records or information regarding the diagnosis, treatment or condition to insurance company or liable third parties

Initial_____I agree that I am obligated to pay Walker Physical Therapy and Wellness for any service rendered and not covered by insurance to include copays, deductibles and coinsurances. I understand that if my account becomes delinquent, I am obligated to reimburse Walker Physical Therapy and Wellness for all interest charges, late payment fees, collection fees (which can exceed 50% of the outstanding balance), and court costs resulting from delinquency.

Initial_____I understand the regulations stated above and I am fully aware of and accept my responsibilities. I also understand that if my account is not paid in full when past due, the past due account can be reported to a credit bureau, and it may affect my credit history. I understand that all insurance policies are different and it is impossible for Walker Physical Therapy and Wellness to know the specifics of my plan.

Initial_____I understand that I am responsible for payment of all services received and to inform Walker Physical Therapy and Wellness of any changes to my insurance

Insurance Information:

Primary Insurance Insured name:_____DOB:_____

Company:_____ Phone:_____

Provider ID: _____Group:_____

Secondary Insurance Insured name:_____DOB:_____

Company_____Phone:_____

Provider ID_____Group:_____

Consent To Treat:

Patient Name:_____ **DOB:** _____

Initial_____ I,_____ (guardian) give my consent for Walker Physical Therapy & Wellness to provide physical therapy evaluation as may be beneficial in the professional judgement of the child's therapist, and primary care physician. I am aware that no guarantee has been made to the effect of physical therapy on my child.

Initial_____ My child, _____(child name) has permission to participate in a natural environment setting during therapy sessions which may include peers, students, volunteers.

Initial_____ I consent to the use of gross motor play with my child and that Walker Physical Therapy & Wellness are not responsible for any injury/accident that occurs to my child during this type of play

I authorize photos/videos to be used for the following: (Initial if yes; leave blank if no)
To track progress:_____ For display on website or Facebook Page:_____

Initial_____ I have been provided copy of the 'Notice Of Privacy Practices'

Print Name: _____

Signature: _____**Date:**_____

Attendance Policy:

Initial_____ Consistent therapy attendance is critical for your child's success and required by Walker Physical Therapy & Wellness. Your child maybe taken off caseload for **3 missed visits** without adequate notice.

Initial_____I am aware that if I do not comply with the home exercise program and or attendance policy my child can be discharged due to non-compliance

I acknowledge that I understand the above policies and that my compliance is required to continue physical therapy services with Walker Physical Therapy & Wellness.

Print Name:_____

Signature:_____**Date:**_____

Authorization To Release Protected Information:

I authorize Walker Physical Therapy & Wellness to release protected/medical information of:

Patient Name:_____DOB:_____

To: *(Whom of the below contacts do you want to allow information to be shared with?)*

Pediatrician:_____Physician(s):_____

Family Members:_____School:_____

Early Interventionist:_____ Other:_____

For the purpose of:_____

I authorize the release of the following types of information via document or verbal: (Please Initial)

PT Evaluation/goals:_____PT Notes:_____

Therapy Progress/ITP:_____Medical history_____

I understand that I may revoke this authorization at any time by submitting a written request to Walker Physical Therapy & Wellness. Such a revocation does not apply to prior date of request.

Print Name:_____

Signature:_____**Date:**_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING HEALTH INFORMATION

We understand that information about you and your health is personal. We are committed to protecting your health information. We will create a record of the care and services you receive at Walker Physical Therapy and Wellness. We use and share this record to provide you with quality care and to comply with certain legal requirements. This record will be available to all health care professionals who need access as described in this Notice, many of whom will be involved in your treatment. This Notice will apply to all of the records of your care that we maintain. This Notice will tell you about the ways we may use and share your health information. It also describes your rights and certain obligations we have regarding how we use and share your health information.

We are required by law to:

- Maintain the privacy of your health information as outlined in this Notice
- Provide you notice of our legal duties and privacy practices with respect to your health information
- Follow the terms of the Notice that are currently in effect

WHO WILL FOLLOW THIS NOTICE?

- Any health care professional authorized to enter information into your Walker Physical Therapy and Wellness medical record, including therapist and other
and personnel.
- All employees, staff, volunteers, and other personnel

In addition, our facilities may share health information with each other for treatment, payment or health care operations as described in this Notice.

HOW IS YOUR INFORMATION USED?

For Treatment We may use and share your health information to provide, coordinate, or manage your health care and related services, both among our own providers, and with others involved in your care.

For Payment Generally, we may use and share your health information with others to bill and collect payment for the treatment and services we provide to you. Before you receive scheduled services, we may contact your health plan to ask for approval of payment, or we might contact Insurance or Medicaid to inquire as to whether you qualify for coverage. We may also share portions of your health information with billing departments, insurance companies, health plans and their agents, and consumer reporting agencies.

For Health Care Operations We may use and share health information to conduct our business activities and health care operations that assist us in improving the quality and cost of the care we provide to you and other patients.

Appointment Reminders We may use and share health information to contact you as a reminder that you have an appointment for treatment.

Treatment Alternatives We may use and share health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-−Related Benefits and Services We may use and share health information to tell you about health-−related benefits or services that may be of interest to you.

Business Associates We sometimes hire other people to help us perform our services or operate our entities. We may share your health information with them so that they can perform the job we have asked them to do. We require them to protect your health information and keep it confidential.

Individuals Involved in Your Care or Payment for Your Care We may share your health information with a family member, personal representative, friend or other person you identify.We will share information that is directly related to their involvement in your care or payment for your care.

SPECIAL SITUATIONS

In some situations, we may use or share your health information without your permission or allowing you an opportunity to object. Examples of these situations include:

When Required by Law
For Health Oversight Activities
For a Legal Proceeding
To Law Enforcement
To Avoid a Serious Threat to Health or Safety
For Research
For Specialized Government Functions

STATE AND FEDERAL LAWS

Sometimes, state or federal laws require us to protect or share your health information in keeping with or in addition to the ways stated in this Notice.

Inspections and Surveys One or more of our facilities and services are subject to inspection by state and federal agencies and accreditation representatives who may review patient health information, which we are required to provide. For example,
A licensing board may also review records when evaluating a provider's qualifications or investigating a matter.

OTHER USES OF HEALTH INFORMATION

In most cases, we require your written permission to use or share psychotherapy notes, or health information for marketing purposes, or to share your information in a way that constitutes sale of health information. Before we use or share your health information in a manner not covered by this Notice or required or permitted by applicable laws, we will ask for your written permission. We may also remove all identifiers from your information to make it anonymous, and use or share it for other purposes.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding the health information we maintain about you:

1. Access To A Copy Of Your Health Records

You can ask to see and get a copy of your health record and other health informat ion. You may not be able to get all of your information in a few special cases.

- In most cases, copies of your health record will be given to you within 30 days, but this time frame can be extended for another 30 days, if needed.
- You may have to pay for the cost of copying and mailing if you request copies and mailing. To request a copy of your health record, you must write a letter to Walker Physical Therapy and Wellness.

2. Revoke An Authorization

If you have provided us permission to use or share your health information, you may revoke that permission at any time by writing a letter to Walker Physical Therapy and Wellness. If you revoke your permission, we will no longer use or share your health information for the reasons covered by your written authorization. You understand that we are unable to take back any information we have already shared before you notified us of your revocation.

3. Request Changes To Your Health Information

You can ask to change or add information to your health record that you think is wrong or incomplete. A request to change your health information is also known as a "request for amendment." The provider has the right to decide whether to grant the request for amendment.

4. Obtain A List Of When And Why Your Health Information Was Shared

You have the right to request an "accounting of disclosures." This is a list of the people with whom your health information has been shared (it does not include those involved in treatment, payment, or for health care operations, or as authorized by you).

5. Request Restrictions On Sharing Of Your Information

You have the right to request a restriction or limitation on the health information we use or share about you for treatment, payment or health care operations. You also have the right to request that we limit the health information we share about you to someone who is involved in your care, such as a family member or friend.

6. Request That We Change How We Contact You

You can make reasonable requests to be contacted at different places or in different ways.