New Patient Registration Form (Child)

Today's Date____________________________

Patient Information: Name____Age______________________

SSN#______________________________D.O.B. _____________________Sex (circle one) M F Marital Status_____________

Address_____________________________________City____________________________State_________Zip______________

Home Phone ____________________ Cell Phone ______________________ Email __________________________________

Employer ____ Work Phone___________________

Employer's Address_______________________________________City_______________State_________Zip______________

Responsible Party: Name: ____

Relation to Patient □ Spouse □ Parent □ Guardian

DOB: ________________________ SSN# _____________________________________

Address ____ Home Phone __________________

Street City State Zip

Employer____ Cell Phone _____________________________

Employer's Address ____Work Phone _____________________

Street City State Zip

Primary Insurance Name:____

Address ____City, State, Zip ____

Policy #____ Group # ________________________________

Policy Holder Name ____

DOB:_________________ SSN#____Cell Phone___________________

Employer____ Work Phone___________________

Employer's Address ____

Street City State Zip

Secondary Insurance Name: ____

Address____ City, State, Zip ____

Policy # ____ Group # ____

Policy Holder Name ____D.O.B._______________________________

Misc.
Info.____

By signing, I attest that all information provided is true and complete and that my injury/illness is not work related. I authorize the release of any necessary medical information and payment of medical benefits to the physician for services rendered. I understand and agree that:

1) I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood the notice;
2) I am fully responsible for all charges to me including the balance remaining after payment of insurance benefits (as per your insurance contract);
3) Payment is expected on the day services are rendered unless prior arrangements are made; **** Your copay is __________.****

Patient or Responsible Party Signature: ____ Date __________

Patient Consent Form

I hereby consent to rehabilitation treatment as prescribed by my physician, or as deemed necessary by the treating therapist.

The patient is responsible for charges incurred, regardless of insurance coverage. If we have a contract with your insurance carrier, we will file the claim for your services. If the insurance company denies payment for no referral, non-covered services, deductible, etc, I am responsible for all balances due.

Centex Rehabilitation, LLC Accepts assignment for Medicare patients.

I understand, in some instances, the applicable rehabilitation charges billed to my insurance company may not be covered under my insurance policy. I agree to be responsible for any portion of my bill not covered by insurance**. I understand it is my responsibility for checking on my insurance benefits and complying with the requirements of the policy.**

I have read and understand the above statements.

____ ________________________

Signature of Patient or Parent/Guardian Date

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- I have been informed by you of your notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Centex Rehabilitation has the right to change its Notice of Privacy Practices from time to time and that I may contact Centex Rehabilitation at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____

Patient Signature: ______________________________________

Date: ____

Child's Name:____________________________ DOB: _________ Age: ________ Female:___ Male: ___

Current Diagnosis: _________________________ Referring Physician: ___________________________

Home Address: ____

Guardian's Name: ______________________________ Home Phone: ____________________________

Cell Phone: ________________________________ Work Phone: ________________________________

Child's School _______________________________ Grade Level: _______________________________

Please list Name(s) of Specialist(s) your child has been seeing and their conclusions and suggestions: ___

____

____

____

Language(s) spoken at home: _________________________

Name and ages of all household members: ____

What concerns do you have about your child: ____

____

When was the difficulty first noticed? By whom? ____

____

Special equipment used by your child:

wheelchair: _____ eye glasses: _____ hearing aids: _____ orthotics: _____

communication device: _____ walker: _____ shunt: _____ other: _____

Prenatal Birth History:

What was the mother's general health during pregnancy (illnesses, accidents, medications, unusual conditions, etc.) ____

____

Length of Pregnancy: __________ weeks Type of Delivery: Vaginal _________ C-section_________

Complications: Yes No If yes, please explain: ____

____

General Condition of Child at Birth: ____

Medical History:

Has your child ever suffered from, or been diagnosed with, any of the following (circle all that apply):

ADD/ADHD	Allergies/ Hayfever	Asperger's Syndrome	Asthma	Anemia	Autism
Blood Pressure Problems	Cystic Fibrosis	Developmental Delay	Juvenile Diabetes	Dyslexia	Ear Infection
Eczema	Epilepsy/ Seizures	Gastric Reflux	Headaches	Heart Defect	Kidney Infection
Learning Disorder	Pervasive Dev. Disorder	Encephalitis	Ear Infections	Tonsillitis	Ear Tubes

Is your child allergic to latex? Yes No

Does your child follow a special diet? Yes No If yes please explain:__________________________

Please list all current medications: ____

Please list all previous surgeries and/or hospitalizations: ____

Developmental/Social History:

Provide the approximate ages at which the child began to do the following activities:

Crawl: ___________ Sit: ___________ Pull to Stand: ___________ Stand Alone: ___________

Walk: ___________ Feed Self: ___________ Dress Self: ___________ Use Toilet: ___________

Does your child fear strangers: Yes No Does your child have difficulty sleeping: Yes No

Does your child have difficulty participating in activities which require:

Small muscle coordination ___________ Grasping ___________ Reaching ___________

Pinching ___________ Cutting ___________ Drawing ___________ Other: ___________

Large muscle coordination ___________ Walking ___________ Running ___________

Jumping ___________ Throwing ___________ Catching ___________ Other: ___________

Describe the child's response to sound:

___________ responds to all sounds ___________ responds to loud sounds only

___________ inconsistently responds to sounds ___________ responds emotionally to sounds

How does the child usually communicate: Gestures___________ Single Words ___________

Short Phrases ___________ Sentences ___________ Sign Language ___________ Other

How does the child interact with others: Shy ___________ Aggressive ___________

Uncooperative ___________ Makes Eye Contact ___________ Plays on Own ___________

Plays well with others ___________ Able to establish and maintain friendships ___________

Able to initiate play and take turns ___________ Other___________

What are your goals for your child's appointment today? ____

____

____

Any other pertinent information you feel would help us provide better services to your child: __________

____

____

Person completing this form: ____________________________ Relation to child: _____________

Signature: ____________________________ Date: ______________________

Clinic Policies

We strive to provide you with the very best personalized care available. To make this possible we adhere to an important set of policies. Please read them over carefully and indicate your agreement by signing at the bottom.

Cancellations ($25 fee without 24 hour notice):
If you wish to cancel or reschedule an appointment please call us at 254-630-1186 with at least 24 hour advance notice. Advance notice allows someone else (who needs it) access to that appointment time. Thank you in advance for being courteous and responsible.

Failing to Show ($25 fee):
If you fail to show for an appointment without notice, your account will be billed $25 and all future appointments you have scheduled will be removed. You may reschedule these appointments again on a "first come, first serve basis".

Tardiness:
If you are more than 10 minutes late to your appointment you will be asked to reschedule as it interferes with the next patient's appointment. Understand that your appointment time is saved specifically for you and if you are late you affect your therapy, as well as negatively affecting other patients who arrive promptly.

Returned Checks & Delinquent Accounts:
In the event we have a check returned, a $25.00 returned check fee will be applied to your account. All accounts that become delinquent and that are forwarded to a collection agency will be charged a fee of 30% of the balance.

Family and Guests in Clinic:
One family member may accompany you in the clinic. We reserve the right to refuse guest in the clinic area. Brothers and sisters of patients are not allowed into the treatment area.

Children in Clinic:
One child may accompany you in the clinic but needs to be supervised and must stay off clinic equipment. We reserve the right to end the treatment session should the child become disruptive to your treatment and to others. By signing below, you acknowledge and agree that neither Centex Rehabilitation, nor any of its members, employees or representatives, shall have any responsibility to supervise your children in the clinic, and you agree to release for yourself and

your children, Centex Rehabilitation and its members, employees or representatives from any and all claims of any kind that you or your children may have against any of them at any time hereafter as a result of your children's presence in the clinic or anything arising in connection therewith. Thank you for your understanding and cooperation.

Parents are required to remain on the premises at all times for children who are receiving treatment at Centex Rehabilitation.

Insurance:
We may attempt to verify your insurance benefits as a courtesy to you. However, we strongly encourage you to know your benefits for physical and occupational therapy. Please be aware that you are ultimately responsible for payment.

Cell Phones:
If you must have your cell phone on for emergency purposes only, please put it on vibrate and keep calls to a minimum. Both your time and the therapist's time is important. Please respect this by holding off on calls until your therapy is over.

Participation:
It is your responsibility to be compliant with your physical therapy appointments and progress to meet your goals. If you are being seen for a workers compensation injury, we are required to communicate missed or cancelled appointments to your case manager and/or insurance company.

1. Understand that it is my responsibility to consult a physician before beginning any exercise program.
2. I am aware that there exists the possibility of certain conditions occurring during or following training and/or exercise. This include, but are not limited to: mild light headaches, fainting, abnormalities of blood pressure and/or heart rate, injuries to bones, joints and muscles, neck or spinal injuries, ineffective heart function, and in rare but serious instances, heart attach, stroke, or death.
3. I understand that I am voluntarily participating in these activities and understand that I may, at any time, choose not to participate in a particular activity.
4. I understand that I may not use any clinic equipment or participate in any clinic activity outside the course of my physical or occupational therapy treatment without discussion with the physical or occupational therapist.
5. I agree and have been informed that exercise involves possible risks and all exercises are undertaken at my sole risk and that neither Centex Rehabilitation, nor its directors, employees or agents shall be liable to me or any other person, for any claims, demands, actions or causes of action for injuries or other damages, whatsoever, to my person or property arising out of or connected with my use of clinical activities, classes or programs. I do hereby release and discharge Centex Rehabilitation thereof from all such claims, demands, actions or causes of action for such injuries or damages sustained by me.

I have carefully read and agree to all of the above policies of Centex Rehabilitation. In the event such policies are broken, I agree to the consequences set forth.

Patient Signature Date