



PEDIATRIC INTAKE FORM

				Date:	
Child's Primary Care Ph	nysician				
Patient Information:					
Child's Name (Last, Firs	st, MI)	M/F _ Sex	// DOB	Legal Guardian Name	
Home Address					
City, State	Zip Code	() Primai	ry Phone	()_ Secondary Phor	ne
Cell Phone Carrier Com	pany Lega	al Guardiar	Email Addres	SS	
Insurance Information	:				
Payment Method (Circle	e One) : Money Orde	r Check	< Visa/ Ma	sterCard Insurance	Contract
Primary Insurance	Policy # / Sponsors	SSN (Trica	are only)	Group #	
Policy Holder Name/ Sp	onsor Name			Policy Holder DOB/Spo	onsor DOB
Secondary Insurance	Policy #			Group #	
Emergency Contact In	formation:				
Last Name			First Name		
Contact Phone Number			Relationship		

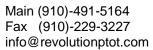


Section 1- Knowr	n Allergie	PATIENT HISTOR	Y	
What type(s) of all	ergies do	es the child have?		
☐ Yes ☐ No	Latex (p	olease provide details):		
☐ Yes ☐ No	Food (p	lease provide details):		
☐ Yes ☐ No		Contact Allergies (please details):		
☐ Yes ☐ No	Medica	tion (please provide details):		
Section 2- Genera	al Questi	ons		
What are your prin	nary cond	erns and reason for referral?		
What are your prin	nary goal	s for your child's therapy?		
Please list the nar	mes of the	e programs/people that work	with your child outside of R	
Service		Practice/ School Name	Provider Name	Last Seen
Occupational Their	rapist			
Speech Therapist				
Physical Therapist	t			
Counselor/ Psycho				
Caseworker/ Coor	dinator			
Specialty Doctor				
Other				
Section 3- Pregna	ancy & D	elivery		
Did the child's mot describe:	her have	any illnesses or complication	s during pregnancy or deli	very? Please

5860 Yadkin Road Fayetteville, NC 28303

Main (910)-491-5164 Fax (910)-229-3227 info@revolutionptot.com

Was the child premature?	☐ Yes ☐ No	
Born at how many weeks	gestation:	Birth Weight:
Did your child require any	medical procedures before,	during, or after birth? Please describe:
Section 4- Developmenta	al History	
Please indicate at what ag	ge each major milestone was	s reached:
Sitting up by self:	Crawling:	Walking:
Section 5- Feeding Histo	orv	
	-	
Does your child have any	feeding/ eating problems? P	Please describe:
Did your child have any co		
	ent eating habits and typical	
Section 6- Hearing and V	/ision History	
Has your child had his/her	hearing tested? If yes, whe	n and what were the results?
Has your child had his/her	vision tested? If yes, what w	were the results?
		at any dition 0
Does your child wear glass	ses or hearing aids? For wh	at condition?





Section 7- General History
Does your child have tantrums: ☐ Yes ☐ No
If so, how often?
How does your child handle change and variation in routine?
What games, activities, and toys does your child enjoy playing?
Describe how your child interacts with other children:
Describe your child's sleeping habits/patterns:



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Notice of Privacy Practices

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Carteret Physical Therapy Associates, Inc. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments.

Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

www.revolutionptot.com

Fund raising. We will not use your name and address to support our fund-raising efforts. If you do want to participate in fund-raising please inform the Office Coordinator.



Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Revolution USA Inc. Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Office Coordinator at the clinic where you are a patient. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints /Contact Person

If you would like additional information or you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Tremayne Thurman, Director of Operations Revolution USA Inc. 5860 Yadkin Rd Fayetteville, NC 28303

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date

This Notice is effective on or after November 10, 201	This	Notice	is	effective	on	or	after	November	10,	201
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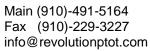
Legal Guardian Signa	ture:
Name of Patient:	
Date:	



Office Policy Summary

Please Initial All

Account Balances:	Unless other arrangements have been made	e, account balances are due
Insurance Policies:	at the time of check in for all patients. You are responsible for understanding your for services and/ or co-payments are due at \$20.00 fee for returned checks. You are responsed by your plan. Should any changes of please be aware it is your responsibility to restaff. Please give us a call if you have any questions.	check in. There will be a ponsible for any service not occur with your insurance, elay that information to our
No Show Policy:	Cancellations require 24-hour advanced In general, a \$50.00 fee will be applied to you late-cancel. You may be required to resched applied to your account. If your child become before your appointment, please call to cand will be waived if you reschedule your missed week. Note that only 1 reschedule a week is understand that life is dynamic, and "stuff" h	notice. our account if you no-show or dule, or a no-show fee will be es sick less than 24 hours cel your appointment. The fee d appointment for the same allowed. Nevertheless, we
Consent for Treatment:	if you have any questions. I hereby authorize Revolution Inc. to provide therapy treatment and services to myself or doing so, I understand, acknowledge and af and related services may involve bodily concontact of a sensitive nature. I also authorize information that may be necessary for my cafacsimile transmission. I further consent that that all medical history has been completed	patient named below. In firm that such rehabilitation tact, touching, and/or direct e the release of such are via mail, electronic or by signing below I certify
Treatment of Minors:	I, as parent/guardian of a minor receiving tree hereby agree and understand that I have be premises during any such treatment, and waresulting from failure to do so.	eatment here under, do een advised to remain on the
Legal Guardian Signature Name of Patient		 Date





APPOINTMENT AND CANCELLATION POLICY

At Revolution Inc., we understand that life happens. Accommodations will be made within the administration's discretion during any extenuating circumstances. To achieve maximum benefits, it is important for your child to attend scheduled therapy appointments. By attending the scheduled appointments, as deemed medically necessary, and by carrying over the recommended home exercises, your child can make progress.

PLEASE READ THE FOLLOWING EXPECTATIONS AND ADD YOUR INTIALS

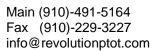
To cancel appointment, please call: 910.491.51	64; you can call 24 hours a day, 365 days
a year	
When not in treatment, children will be supervitreatment parent or caregiver will stay on Revolution L	
Contacting after hours (I/we) will leave name, t message of why (I/we) need to cancel appointment on	• •
(I/we) are aware that CANCELLATION requires 2	24 hours' notice
A CANCELLATION within same day of the appoin	ntment time is a NO SHOW
TWO (2) NO SHOW appointments or THREE (3) removal from a recurring appointment time and/or my discharged	
Please discuss your child's appointment needs with his Office Assistant. The more you communicate about you the therapist to plan your child's individualized programyou are certain your child will be able to attend and co	ur child's needs, the more helpful it is for m. Please schedule appointments only if
Thank you for choosing Revolution USA as your physica provider.	al, occupational, and speech therapy
I,, have read and u	nderstand the above Appointments and
Cancellation Policy.	
Parent/Guardian Signature:	Date:
Cx/NS Form Verbally Reviewed with Patient	PT/OT/SLP InitialsDate
Cx/NS Form Verbally Reviewed for Completeness	PT/OT/SLP InitialsDate
Cx/NS Form Uploaded into Practice Perfect	Date



Thank you for your cooperation!

Authorization for Release of Information

Signature of Patient or Respons	ible Party	Date
Name of Patient		
<u>Designa</u>	ntion for Release of Infor	<u>mation</u>
I hereby authorize one or all the de	signated parties below to request and	
to treatment and payment. I unders	ing my child's treatment, payment, or tand that the identity of designated pa	
to treatment and payment. I unders release of any information occurs.		arties must be verified before the
release of any information occurs. Name:	tand that the identity of designated pa	arties must be verified before the





Financial Policy

Thank you for choosing Revolution USA Inc as your therapy provider. We are committed to your successful treatment. Please understand that in order to provide the best treatment and meet your needs, we need you to accept total financial responsibility. We consider payment of your bill an important part of your treatment. The following is a statement of our Financial Policy that we ask that you read and sign prior to treatment.

All patients (or patient representatives) must complete our Patient Intake form before seeing a treatment provider.

- Full payment us due at the time of service
- We accept checks, money orders, credit
- We offer an extended payment plan

Regarding Insurance

Your insurance policy is a contract between you and your insurance company; we are not party to that contract. We may accept assignment of insurance benefits your second visit. However, we do require a portion of the bill to be paid at time of service. The balance is your responsibility whether the insurance pays or not. We cannot bill your insurance company unless you give us your complete insurance information. In the event we do accept assignment of benefits, we may ask that you be pre-approved on out extended payment plan or provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 60 days, the balance will be automatically transferred to you, your credit card, or the extended payment plan. Please be aware that some, and perhaps all, of the services provided may not be covered services and thus considered reasonable and necessary under your insurance policy.

Regarding insurance plan where we are participating provider

All co-pays and deductibles are due at the time of treatment. In the event that your insurance coverage changes to a plan where we are not participating provider, the provisions in the paragraph above apply.

Adult & Minor Patients

Adult patients are responsible for full payment at the time of service. The adult accompanying a minor and the parents or guardians of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless arrangements have been made in advance to use an approved credit plan, check, or credit card to make payment.

Certificate: I have read and agree to the terms of this Financia	Policy.
X	
Patient Signature or Responsible Party	Date