Jodi Gilray PT
PEDIATRIC THERAPY

Patient Information

Patient's Name:_____ Date of Birth:_____

Age:_____ Grade:_____ ▢ Male ▢ Female

Address: _____

Mother/Guardian's Name:_____ Marital Status:_____

Address(if different):_____

Home#_____ Cell#_____ Work#_____

Email Address:_____

Occupation/Employer:_____

Father/Guardian's Name:_____ Marital Status:_____

Address(if different):_____

Home#_____ Cell#_____ Work#_____

Email Address:_____

Occupation/Employer:_____

Other persons/age living in home:_____

_____

May we leave messages regarding appointments or continuing care on your voicemail? Yes No

Insurance Information

Policyholder:_____ Relationship to Patient:_____

Date of Birth:_____ SSN:_____ Employer:_____

Insurance Company: _____Policy #_____ Group #_____

Secondary Insurance: _____Policy #_____ Group #_____

I certify that I, and/or my dependents have insurance coverage described above and authorize payment directly to Jodi Gilray PT, PLLC or all insurance benefits, if any, otherwise payable to me for services rendered on my behalf or my dependents. The above-name may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services. I authorize the use of my signature on all insurance submissions.

_____

Signature of Parent/Guardian Date

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Referral Sources

Patient's Name: _____ Date of Birth: _____Today's Date: _____

Pediatrician:_____

Referring Physician (if different):_____

Specialty Physicians:_____

_____

Previous or current Physical, Occupational or Speech Therapy (if any) (List all types, dates, providers, and duration)

_____

What is the current reason for coming to therapy?_____

_____

Medical History

Check all that apply	Yes	No	Check all that apply	Yes	No	Check all that apply	Yes	No
Delays in development			Pain			Surgeries		
Learning difficulties			History of trauma			Pneumonia		
Torticollis			History of abuse/neglect			Breathing problems		
Problems with speech			Abnormal gait/run			Lung disease		
Feeding difficulties			Walks on toes			Asthma		
Reflux			Frequent falls			Tracheostomy		
G-Tube placement			Orthotics/prosthetics			Heart Murmur		
Hearing aids			Hip subluxation/dislocation			Congenital heart defect		
Glasses/contacts			Contractures			Patent ductus arteriosus		
Eye surgery			Fractures			Cardiac surgery		
Frequent ear infections			Seizure disorder			Snores/night terrors		
Frequent infections (other)			Cerebral Palsy			Sleep problems		
Ear tubes			Hydrocephalus/shunt			Dizziness		
Tonsillectomy			Head injury			Fatigue		
Appendectomy			Depressed mood			Cancer		
Diabetes			Autism			Allergies		
Thyroid/Lupus/Arthritis			ADD/ADHD					
Spina Bifida			Anxiety					

Please list any other pertinent medical information including surgical history and/or explain any boxes checked "Yes."

Do you use: ▢Braces ▢Splints/Orthotics ▢Stander ▢Walker▢Wheelchair

Have you had any diagnostic imaging: ▢ X-rays ▢ MRI ▢CT scan ▢Swallow Study ▢Other: _____

If so, what was the place and date?:_____

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Medications / Allergies

Patient's Name: _____ Date of Birth: _____Today's Date: _____

Medications (Please include prescription, over the counter, herbals, vitamins/minerals, dietary supplements)	Dose	Frequency

Does this patient have any allergies?:_____

What kind? ▢ Drug Allergy ▢ Food Allergy ▢Latex Allergy ▢ Other Allergies

Allergens:_____

Reactions:_____Medications for allergens:_____

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Birth / Developmental History

Patient's Name: _____ Date of Birth: _____Today's Date: _____

Child was born: ▢full term ▢premature (if so, how many weeks?_____)

Birth weight: _____ Current weight: _____ (Percentile:_____)

Pregnancy: ▢Single ▢Twins ▢Complicated (if so, describe_____)

Drug exposure in utero: ▢prescription ▢alcohol ▢ illegal

Delivery: ▢Vaginal ▢planned c-section ▢emergency c-section

Were there complications with delivery?_____

Was child placed in Newborn Intensive Care Unit (NICU)? If yes, how long?_____

Beside birth, please list any hospitalizations and surgeries:_____

_____

Please describe any other medical issues or complications during pregnancy or at birth: _____

_____

Please check all that apply to your child as an infant:

Fussy		Quiet		Floppy		Stiff	
Active		Calm		Easy baby		Spit up often	
Feeding difficulties		Always "on the go"		Sensitivities		Poor sleep patterns	

Please indicate approximate age your child achieved the following milestones:

Skill	Age	Skill	Age	Skill	Age
Rolled		Sat alone		Crawled	
Pulled to standing		Walked Alone		Started talking	
Clapped hands		Fed him/herself		Dressed self	
Walk up stairs		Ride a bike		Pump swing	

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Patient Health Questionnaire

Patient's Name: _____ Date of Birth: _____ Date: _____

Describe your pain or symptoms (i.e ache, deep, sharp, stabbing, hot cold, sensitive, sharp, itchy):_____

_____

When did your symptoms begin? _____

Did symptoms occur suddenly, gradually, or due to an accident or activity? _____

_____

What causes or increases your pain? _____

What relieves your symptoms?_____

Do you have difficulties with your job or schooling due to pain? ☐ Yes ☐ No Explain:_____

_____

What daily activities are you limited or unable to do because of your pain? (be specific):_____

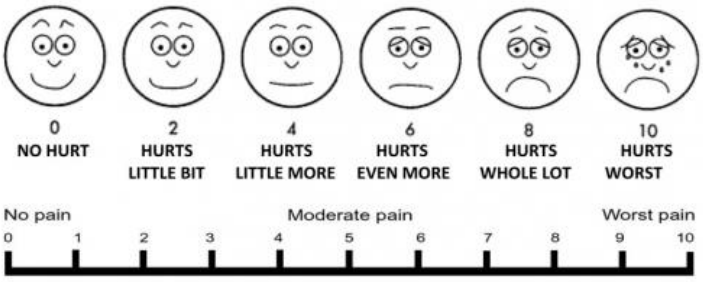
_____

What physical or extracurricular activities do you normally participate in? _____

_____

Are your symptoms getting: ▢Better ▢Worse ▢Unchanging

If you have pain, rate the intensity on the scale below:



Rate pain from 0 to 10:

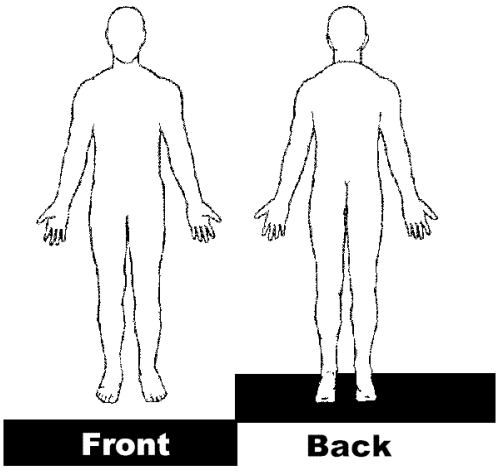
At Best?_____

At Worst?_____

In Morning?_____

At Night?_____

Please mark the location where your pain and/or numbness is located:



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Attendance Policy

Patient's Name: _____ Date of Birth: _____

1. Regular attendance is required of all patients scheduled. Patients will not benefit from sporadic intervention.
2. Appointment reminders are texted as a courtesy to families the day before their appointment. If a patient is unable to keep an appointment for a therapy session, the clinic should be notified 24 hours in advance. The voicemail is available 24 hours a day. Please state the reason for cancellation.
3. Families that cancel frequently or fail to attend scheduled appointments will only be allowed to be scheduled on the requested day of treatment or will be discharged.
4. When patients are consistently late, the therapist has the discretion to treat and/or cancel further sessions.
5. Parents/guardians can observe sessions as desired. Parents are not required to do so unless requested by the therapist for the therapeutic educational purposes. Children over the age of 2 years generally perform better without the parent in the room.
6. CMDP does not permit biological parents to attend therapy sessions and they will be asked to wait in the waiting room should they arrive.
7. Please feel free to contact management if special consideration is needed, or if you have any questions regarding this policy.

_____ _____

Parent/ Guardian's Signature Date

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Consent to Treat and HIPAA Authorization

Patient's Name:_____ Date of Birth:_____

Our practice is required by law to maintain the privacy of your health information. We are dedicated to maintaining the confidentiality of your health information.

I hereby authorize treatment and use/disclosure of protected health information about my child as described below.

1. I understand that I have the right to ask and have any questions answered prior to receiving treatment, including any risks or alternatives to the treatment plan that has been prescribed by me. By signing below, I consent to have a Jodi Gilray PT, PLLC therapist provide treatment. Should I be unable to bring my child in for therapy, a signed release to have a friend/family member bring child in will serve as my consent to treat.
2. Jodi Gilray PT, PLLC and its employees/contractors are authorized to use or disclose health information that is pertinent or required for therapy purposes. I have a right to a paper copy of the Notice of Privacy Practices at any time.
3. I understand that Jodi Gilray PT, PLLC may be disclosing protected health information to a patient's insurance company and physician for continuing care. I also understand that the information used or disclosed may be subject to multiple disclosures by the individual or facility receiving the information. Upon written request, I have a right to a copy of my child's health information, including medical records and billing records and may be charged the reasonable cost based fee imposed by Jodi Gilray PT, PLLC.
4. I may revoke the authorization by notifying Jodi Gilray PT, PLLC in writing. However, I understand that any action taken previously to revocation of this authorization cannot be reversed, and my revocation will not affect those actions. The authorization expires when a patient is discharged by Jodi Gilray PT, PLLC or when written notice to revoke authorization is received. Prior notification will be given to the parent or guardian before information is released.
5. I do hereby give my consent for speech, occupational and physical therapy according to the guidelines established by the referring physician and the therapist. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact.
6. I, as parent/guardian of minor receiving treatment, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.
7. I know and agree that Jodi Gilray, PT PLLC is not responsible for loss or damage of personal valuables.

_____ _____

Parent/Guardian Signature Date

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Payment / Insurance Policy

Patient's Name: _____ Date of Birth: _____

Jodi Gilray PT, PLLC is dedicated to providing quality affordable healthcare to all patients. Your child's physician believes that this treatment is medically necessary. Please check the appropriate box and fill out parent/guardian name as it applies to you and sign the bottom.

☐ **Private Insurance Patients:** I, _____, understand that my private primary and secondary insurance will be billed for my child's therapy services. Jodi Gilray PT, PLLC will file all charges incurred with your insurance company. All co-payments are due at time of service. Any unpaid balance will be transferred to you and we will discuss available payment policies. Knowing your insurance benefits is your responsibility. Although we verify your insurance as a courtesy, you are strongly encouraged to contact your insurance company with any questions regarding your policy. Please inform us immediately of any changes in insurance coverage or providers.

☐ **Medicaid/AHCCCS Patients:** I, _____, understand that I am financially responsible for all charges incurred if my child's Medicaid is terminated for any reason. It is also my responsibility to be aware of and inform Jodi Gilray, PT PLLC of any and all changes in coverage.

☐ **Private Pay Patients:** I, _____, understand that I am responsible for all charges incurred at Jodi Gilray PT, PLLC and will be held liable for payments in full. I agree to pay $200 for the initial evaluation and then $95.00 per treatment at the time of service. We will discuss available payment policies if needed.

☐ **CMDP Patients:** I, _____, understand that I am responsible to inform Jodi Gilray PT, PLLC of any changes in coverage and/or guardianship.

_____ _____

Parent/Guardian Signature Date