Patient Information Form **Date: _____**

Child's Full Name: _____DOB:_____ Age: _____ Sex: M/F
Child's Address: _____ City: _____State: _____Zip: _____
Child's School/Daycare: _____Phone: _____

Guardian Name (1) _____ Street Address: _____
City: _____ State: _____ Zip: _____ Email: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Preferred Method of Contact (please circle): Home Work Cell Email

Guardian Name (2) _____ Street Address: _____
City: _____ State: _____ Zip: _____ Email: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Preferred Method of Contact (please circle): Home Work Cell Email

Emergency Contact: _____Relationship: _____Phone:_____

Referring Physician/Pediatrician (Name/Facility): _____
Physician Phone: _____ Physician Fax: _____

Primary Insurance:
Policy Holder's Name: _____ DOB: _____Relationship: _____
SSN: _____Policy #: _____Group #: _____
Insurance Company: _____ Employer: _____
Insurance Company Address: _____ Phone: _____

Secondary Insurance:
Policy Holder's Name: _____ DOB: _____Relationship: _____
SSN: _____Policy #: _____Group #: _____
Insurance Company: _____ Employer: _____
Insurance Company Address: _____ Phone: _____

Assignment of Payment

Authorized person's signature: I hereby assign the medical benefits to which I am entitled from private insurance and other health plans to Pediatric Developmental Therapy Inc. to release information necessary to secure payment. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Pediatric Developmental Therapy Inc. to receive direct payment for therapy services rendered to my child.

Signed: _____ Date: _____

Release of Information Form **Date: _____**

Child's Name: _____ DOB: _____
Guardian/s: _____
Address: _____City: _____
State: _____Zip Code: _____Phone Number: _____

- I hereby authorize any physician, clinic, hospital, institution or school to release medical and psychological information regarding my child, (Child's Name) _____ to Pediatric Developmental Therapy Inc. I understand that this information is to be used for professional purposes only and that it will be regarded as confidential. I also authorize Pediatric Developmental Therapy Inc. to contact any persons or institutions to obtain any additional information regarding my child, when necessary.

  Signed_____
  (Guardian)

- I hereby authorize Pediatric Developmental Therapy Inc. to release therapy reports regarding my child, (Child's Name) _____, to any entity or professional associated with my child's care (physicians, any clinic, hospital, institution, insurance company, school, and other), with the exception of _____.

  Signed_____
  (Guardian)

- I, _____, give my permission for Pediatric Developmental Therapy Inc. to photograph and/or videotape my child (Child's Name), _____, and use said photos/videos for promotional or teaching purposes.

  Signed_____
  (Guardian)

Consent for Treatment

1. I authorize a therapist with Pediatric Developmental Therapy Inc. to perform the following: Speech, Occupational, or Physical Therapy with (Child's Name) _____.
2. During any treatment session, unforeseen conditions may occur which may necessitate additional or different treatments. I, therefore, authorize a PDT employee or designee, to perform necessary treatments to remedy any unforeseen conditions which may occur.
3. I authorize a healthcare/therapy student to be present in the room during the therapy session for observation purposes: **YES / NO**

_____ _____

Guardian Signature Relationship to Patient Date

Appointments and Cancellation Policy for Medical Appointments

Thank you for choosing Pediatric Developmental Therapy as your therapy provider. The staff and therapists of PDT strive to make your experience here positive and to provide quality care for your child. In order to do so, we take your attendance at scheduled therapy visits very seriously. In order for your child to achieve maximum therapeutic benefits, they must regularly attend their appointments. By coming to your visits and adhering to recommended home exercises, your child can make great progress.

For Scheduled Appointments:

To schedule an appointment, please call our office at 910-483-8331. At the time of your arrival, please sign in at the front desk. A parent or guardian must remain on the premises at all times and must be in the waiting room 5 minutes prior to the end of their child's appointment.

Cancellation of an Appointment:

In order to be respectful of the therapy needs of all of our Pediatric Developmental Therapy children and their families, please be courteous and call our office promptly if you are unable to attend an appointment. If it is necessary to cancel your scheduled appointment, we require that you call a minimum two hours in advance of your scheduled time. You may call our office at 910-483-8331 and advise our receptionist of the cancellation or you may leave a detailed message in the general mailbox if calling after hours. You may not cancel via email at this time.

No Show Policy:

A "no show" is someone who misses an appointment without canceling within two hours of their scheduled appointment or who fails to arrive within 15 minutes of their appointment. "No Shows" cause other children to not be seen in a timely manner and disrupts their therapist's schedule. Most importantly, they cause disruption in your own child's progress toward meeting his or her goals. There will be a $10 charge for each "no show". Three "no shows" will result in the child being discharged from PDT and taken off the current schedule. If the discharged child's family wishers to resume therapy, they will have to contact our office and be placed on the waiting list. Of course, we know that there will be special cases, and will evaluate those as needed on an individual basis.

Late Cancellations:

Cancellations made less than two hours before a scheduled appointment will be considered as a "no show". In addition, if you are more than 15 minutes late for your appointment time, this will also be considered a "no show".

We encourage and recommend you discuss with your therapist and our front office personnel your appointment needs, insurance benefits and any financial concerns you may have. We will not judge or discriminate in anyway, but greatly appreciate the opportunity to help in your situation and its' role in your child's therapy process. From these discussions, your therapist is able to plan your child's individualized program. We ask you to schedule appointments only if you are certain you will be able to attend and commit to those times. Thank you, again for choosing Pediatric Developmental Therapy as your provider. We look forward to serving you and your child.

I, _____, have read and understand the above Appointment and Cancellation Policy.

Signature: _____Date: _____

Employee Signature: _____Date:_____