Patient Registration **Pediatric Physical & Occupational Therapy, PLLC**

Patient Information

Date_____

Patient_____ **DOB**___/___/___ Sex M/F

Mother/Guardian_____ DOB___/___/___ SS#_____

Address_____ Home Phone_____

City/State/Zip_____ Cell Phone _____

Employer_____ Alt Phone_____

E-mail address _____

Father/Guardian_____ DOB___/___/___ SS#_____

Address_____ Cell Phone_____

City/State/Zip_____ Alt Phone_____

Employer_____

E-mail address _____

Children live with: __Mother __Father __Guardian _____

Emergency Contact Person_____ Phone_____Relationship_____

Party Responsible for Payment of Services __Mother __Father__ Guardian _____

Pediatrician/Referring Physician _____

Who referred you to our office?_____

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Authorization of Treatment

I authorize Pediatric Physical & Occupational Therapy, PLLC (PPOT) to perform a physical and/or occupational therapy evaluation, administer treatment as recommended in the initial evaluation and provide therapeutic services as deemed necessary by PPOT. I will receive an explanation of the therapy recommended for my child in understandable terms as well as the possible side effects associated with the treatment.

I further authorize the release of medical information necessary for the completion of insurance forms.

Parent/Guardian Signature_____ **Relationship**_____ **Date**_____

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Insurance Information

Primary_____ Claims Address_____

Policy #_____ Group#_____

Name of Insured_____ DOB __/__/__ Relation_____

Authorized Signature:_____

Secondary Insurance: Yes___ NO___

☐ I decline to go through my insurance. I understand I can change this request at anytime. _____ (initial)

HIPPA Authorization Statement

Authorization for Release of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

My child's therapist from Pediatric Physical & Occupational Therapy, PLLC can discuss my child's case with:

Person	Organization	Telephone Number

The purpose of the disclosure: To communicate with the other therapists/physicians working with the child regarding therapy treatments, progress, concerns, goals and recommendations.

_____ _____

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient:_____

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Acknowledgement of Receipt of Privacy Practices

I have been given a copy of Pediatric Physical & Occupational Therapy, PLLC Notice of Privacy Practices that describes how my health information is used and shared. I understand that Pediatric Physical & Occupational Therapy, PLLC has the right to change this notice at any time. I may obtain a current copy by contacting the office at 845-362-7787.
My signature below constitutes my acknowledgement that I have been provided with a copy of the notice of privacy practices.

_____ _____

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient:_____

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Email Consent

Family email address:_____

□ Yes, I would like to communicate with the office staff and therapists via email. I understand that these emails are confidential.

□ Yes, I would like to receive email notices including newsletters, and upcoming special events. PPOT will keep all information confidential and it will not be disclosed to any outside agency.

□ No, I would not like to receive electronic communications.

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Acknowledge of Receipt of Sick Policy and Financial Policy

_____I have received and read the Sick Policy. (please initial)
_____ I have received and read the Financial and Cancellation Policy. (please initial)