

PEDIATRIC CLIENT INTAKE FORM

Child's Name: _____

Child's Date of Birth: _____ Age: _____ Academic grade level _____ Home Phone #: _____

Address: _____
Street City State Zip

Referring physician _____ Do you wish for PT records to be forwarded to primary care physician if they were not the referring physician? YES NO

Primary Care Physician _____

Names and phone numbers of other specialists that your child sees for this condition _____

Emergency contact name & number _____

How did you hear about Valley Rehabilitation? _____

Guarantor's name and date of birth for primary insurance _____

Guarantor's name and date of birth for secondary insurance _____

HEALTH HISTORY

Diagnosis or Briefly describe your child's problem: _____

This problem started on _____ and is related to ___Illness ___ Fall ___ Auto accident ___ Other

Testing for this condition: ___ x-rays ___ CT scan ___ MRI ___ Other _____

Location of testing _____

___ Surgery (if yes, please elaborate) _____

___ Previous PT, OT or Speech therapy (please indicate which)

If yes, where and for how long? _____

Is your child currently receiving therapy services anywhere else? _____

What aspect of previous therapy do you feel worked well? _____

What aspect of previous therapy do you feel didn't work so well? _____

What things work well for you at home? _____

What things don't work so well for you at home? _____

Please check all conditions that your child **currently has or has had** in the past:

- | | | |
|---------------------------------------|--|------------------------------|
| ___ Seasonal Allergies | ___ Other Allergies (please list) _____ | |
| ___ Seizure Disorder | ___ Asthma | ___ Headaches |
| ___ Kidney Disorder | ___ Diagnosed Cardiac Disease | ___ Congenital Heart Defects |
| ___ Past or present Cancer | ___ Unexplained Weight Change | ___ Vision problems |
| ___ Hearing / Auditory Problems | ___ Depression / Anxiety / ADHD / Bipolar Disorder (please circle) | |
| ___ Diabetes (Circle) Stable Unstable | ___ Prolonged steroid use? | |

FINANCIAL AGREEMENT

Financial Responsibility

I understand that Valley Rehabilitation will verify the specifics of my child's insurance coverage within 72 hours of the initial appointment, and will advise me of any applicable co-payments, co-insurance, or deductibles that will apply to my child's treatment. I agree that I am directly, completely and fully responsible to Valley Rehabilitation for bills submitted for rehabilitation services rendered to my child, including co-payments, co-insurance, deductibles and/or any claims submitted to and denied by the insurance carrier. I understand that applicable co-payments assigned by the insurance carrier must be paid at the time of my child's service. I further understand that applicable co-insurance totals are likely to be billed to me after the completion of my child's treatment, once Valley Rehabilitation has received payment from the primary insurance carrier. I understand that all outstanding balances are due in full within 30 days of invoicing by Valley Rehabilitation. If I cannot pay the outstanding balance in full, I must establish a written payment agreement with Valley Rehabilitation within 30 days of the original invoicing. A finance charge of 1% per month, 12% annum, will apply be applied to unpaid balances that are 31 or more days past due. These finance charges will be included in my payment-in-full. Interest will not be applied to any balance for which a payment agreement has been established, provided that payment on the account is received by Valley Rehabilitation a minimum of every 30 days. If payment is late or not received every 30 days, interest will begin to accrue at the above noted rate until my account is paid in full.

Assignment of Proceeds

I hereby agree to an assignment of proceeds of any monies received by me on behalf of my child with respect of the injury or illness that has caused me to seek Valley Rehabilitation's services for my child. This includes, but is not limited to, any settlement, claim, judgment, verdict or partial settlement which occurs with respect to this injury or illness. I further authorize and direct my insurance carrier, third party insurance carriers and my attorney to pay directly to Valley Rehabilitation any sums that may be due and owed to them for services rendered to my child, and to withhold such sums from any settlement (full or partial), claim, judgment, or verdict as may be necessary to protect them adequately.

Auto Accident

Payment arrangements must be made before my child receive treatment I understand that Valley Rehabilitation does not extend credit for services rendered, even in the event of injuries sustained in an automobile accident or third party liability situation involved in litigation. If financial coverage cannot be established in terms of private payment, medical insurance, auto insurance, homeowner's insurance or other liability insurance or if coverage by any of these entities is terminated I will not be able to receive further treatment from Valley Rehabilitation. I agree that I will instruct all applicable representatives or attorneys to fully pay the amount due to Valley Rehabilitation for services rendered to my child.

Collection Proceedings

Should my child's account become delinquent beyond 120 days, I will be responsible for additional expenses incurred by Valley Rehabilitation in the process of collecting the monies owed on my account, including reasonable legal fees, collection costs and other expenses reasonably incurred.

Notification of Changes

I will notify Valley Rehabilitation of any changes in address, insurance, or attorney representation within 10 days of the change.

I agree that this agreement is primarily for Valley Rehabilitation's protection beyond any lien being filed and financial responsibility being served in consideration of their awaiting payment. This agreement is effective on the first day that I receive rehabilitation services and applies to any services received until the time of my discharge from rehabilitation services.

Printed Parent/Guardian Name _____

Signature _____

Date _____