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Enrollment Packet

Please fill out this form in its entirety and return it to the office manager prior to your first appointment. Please print unless a signature is requested.

General Information: Date:

Patient's Last Name:	**First name:**		**Middle Initial :**
Date of Birth:	**Age:**	**Marital Status (circle one): Single Married**	
SS#	**Sex: M F**	**Diagnosis:**	
Referring Physician:		**Primary Physician:**	
Address:			
City:	**State:**	**Zip Code:**	
Home Phone:	**Work:**	**Cell:**	
Email:			
School:	**Year Round: Y N**	**Grade:**	
Availability:			

Insurance Information:

Primary Insurance	
Policy #:	**Group #:**
Insured Last Name:	**First Name:**
Relationship to Patient:	**Insured's SS#:**
Insured Address:	**City/State/Zip:**
Insured Date of Birth:	**Insured Employer:**
Secondary Insurance:	
Policy #:	**Group #:**
Insured Last Name:	**First Name:**
Relationship to Patient:	**Insured's SS#:**
Insured Address:	**City/State/Zip:**
Insured Date of Birth:	**Insured Employer:**

Please Initial:

_____ I authorize Imagine Pediatric Therapies to bill the above third party payer for all therapy services provided for my child. I understand that this is not a guarantee of payment from my funding source and I understand that I am responsible for any co-pay, deductible or co-insurance not covered by my funding source. If for some reason my insurance does not pay as expected, I will be responsible for payment of my bill. If I am unable to pay the balance in full, I can make payment arrangements with Imagine Pediatric Therapies.

Please initial the following:

Informed Consent:

_____ I authorize Imagine Pediatric Therapies to evaluate and/or treat my child for occupational therapy, physical therapy and/or speech therapy as indicated.

Is your child receiving any outside therapy services? _____ If yes, please indicate where they are receiving services. _____. Most third party payers do not allow services to be billed more than one time per day. If your child is receiving the same services and they are billing for their services, please discuss scheduling options with the office manager.

_____ Under the individuals with Disabilities Education Act (IDEA), Imagine Pediatric Therapies is required by Federal Law to refer any child they service for therapy to the following federal programs: ages birth to 3 will be referred to First Connections and ages 3 to 5 will be referred to Education Services Cooperation at your request. I understand that this law requires Imagine Pediatric Therapies, as healthcare professionals, to refer any child birth to 5 with 25% or greater developmental delay to these services. I have been notified that I can accept or deny any of these services offered to me through these programs, and/or I can choose Imagine Pediatric Therapies to evaluate and treat my child. I understand this requirement and have been given information to further help me understand this law if needed.

Release of Information:

_____ I hereby authorize Imagine Pediatric Therapies to obtain, orally and in writing, all pertinent medical, psychological and educational data from the following sources (ex: physician, school):

_____

_____ I hereby authorize Imagine Pediatric Therapies to disclose , orally and in writing, all pertinent medical, psychological and educational data to the following sources :

_____

_____ I hereby give permission for images of my child captured during therapy exercises with video, photo and/or digital camera to be used by Imagine Pediatric Therapies. Images may be published in any manner including advertising periodicals and website use without any compensation to my child or myself. I understand that I will be given notification prior to the use of any of my child's photographs.

Family History:

Child lives with (Names):_____ Relationship:_____

Other people living in the home (names and ages):_____

_____

Medical History:

Medical Diagnosis:_____

Has your child been hospitalized? O yes O no

If yes, please explain:_____

Has your child's hearing been tested? O yes Ono If yes: O passed O failed

Please check the following things that your child has experienced:

O Allergies:	**O Hearing Difficulties**
O Asthma	**O Learning Disabilities:**
O Convulsions/Seizures:	**O Immunodeficiency :**
O Ear Infections	**O Psychiatric disorder:**
O Frequent Colds	**O Vision Difficulties:**
O Head Injury	**O Mental Retardation:**
O Heart Problems	**O Feeding/Swallowing difficulties:**
O Meningitis	**O**
O Pneumonia	**O**
O R.S.V.	**O Other**

Please list any medications that your child takes on a regular basis:

_____

Birth History:

Delivered at gestational weeks):_____ **Birth Weight:**_____

Please list any complications during pregnancy and/or delivery:

_____

_____

_____

Was your child exposed to recreational drugs, tobacco or alcohol during pregnancy? O yes O no

If yes, please list :_____

Please check all that apply:

O Extended hospitalization at birth: _____

O Oxygen Reason:_____ **Length of Time:**_____

O Feeding Tube Reason:_____ **Length of Time:**_____

O NICU Reason:_____ **Length of Time:**_____

Has your child been hospitalized or undergone surgery other than at birth? O yes O no

If yes, please explain: _____

Developmental History:

Please list the approximate age your child developed the following skills:

Crawled:		**First Word:**	
Walked:		**Drank from a cup:**	
Potty Trained:		**Slept all night:**	

How does your child express his/her wants and needs?_____

Describe a typical day for your child.

_____
_____
_____
_____
_____
_____

What are your primary areas of concern?

_____
_____
_____
_____
_____
_____

Please list your child's strengths:

_____
_____
_____
_____
_____
_____

Please list your child's weaknesses:

_____
_____
_____
_____

_____
_____

Please let us know your child's favorite things (toys, games, foods, etc…):

_____
_____
_____
_____
_____
_____

Is there anything else you would like to share about your child or family history that you think we should know (all information is kept confidential and is used to assess and treat your child accordingly) ? Please indicate if you would like for this information to be omitted from the evaluation report.

_____
_____
_____
_____
_____
_____

Enrollment Packet Completed By:

_____

Print Name **Signature** **Relationship to Patient**