



TAG Physical Therapy Developmental Intake Form:

BIRTH & MEDICAL HISTORY:

Child's date of birth: _____

Circle one: full-term / premature How many weeks gestation was your child born at?: _____

If known, birth weight: _____ Birth Length: _____

Any pregnancy complications? Please list: _____

Any birth complications? Please list: _____

Circle one: c-section / vaginal delivery

Please describe any NICU stay or other hospitalizations: _____

Any other medical conditions not previously described? _____

Any history of imaging (after birth)? Circle any that apply: X-ray Ultrasound MRI or CT scans

Please describe: _____

FEEDING:

Circle ALL that apply: Breastfeeding Bottle feeding Solid foods

Any feeding concerns? _____

ENVIROMENT:

Circle ALL that apply: Attend classes Have other therapies Stay home with parent/nanny/ relative

Specify classes or therapies: _____

PARENTAL CONCERNS:

What brings you to physical therapy? _____

Has your child ever had physical therapy before? If yes, when and for what reason? _____



TAG PHYSICAL THERAPY
111 Penn Street
El Segundo, CA 90245
(310) 426-9570 Fax (310) 426-9572

Date: _____ Referring Doctor: _____

PLEASE PRINT CLEARLY

Home Phone: _____

First Name: _____ Cell Phone: _____

Last Name: _____ Birth Date: _____

Address: _____ Social Security #: _____

City, St., Zip: _____ Sex: _____ Age: _____

Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

City, St., Zip: _____ Drivers License #: _____

Date last worked: _____ Has your employment terminated? _____

Name of spouse or legal guardian: _____

Employer: _____ Birth Date: _____

Address: _____ Work Phone: _____

City, St., Zip: _____ Social Security #: _____

May we leave voicemail messages regarding your appointments at the following?

Home: Yes _____ No _____ Work: Yes _____ No _____ Cell: Yes _____ No _____

Email address: _____

How did you learn of our practice?

Doctor: _____ Family/Friend: _____ Insurance: _____ Internet: _____ Other: _____

Emergency Contact: _____

Relationship: _____ Phone Number: _____

Type of Payment? Insurance _____ Cash _____ Workers Comp _____

Is condition due to one of the following?: Work Related: _____ Auto Accident: _____

Other; Please Describe: _____



TAG PHYSICAL THERAPY FINANCIAL POLICY

Thank you for choosing TAG Physical Therapy - we are committed to providing you with the best possible service and ask that you read and acknowledge the terms of our Financial Policy.

PAYMENT: All payments including copay, coinsurance and deductible are due on the date of service. We accept cash, checks, Visa, MasterCard, and Discover credit cards. As a courtesy to our patients, we will contact your insurance provider to verify your physical therapy coverage. We cannot, however, guarantee the accuracy of the information we receive from your insurance provider.

COINSURANCE/DEDUCTIBLE: If you have a plan with coinsurance percentage or deductible which has not been met, we will estimate the coinsurance/deductible amounts based on what we have been lead to expect your insurance company will pay. Please note that any payment made on the date of service is considered a **DEPOSIT** toward your **ESTIMATED** patient balance. Because this is an estimate, there is always the possibility that you may be either responsible for an additional balance or due a refund. If a refund is due – it will be promptly provided. If it turns out that your insurance company payment is less than expected – you are responsible to promptly pay any additional balance due. An unpaid balance over 30 days past due may be referred to a collection agency.

***I have read and understand the above. Please initial here: _____**

INSURANCE: We encourage you to call your insurance company with any specific questions related to your policy's outpatient physical therapy benefits such as deductible, copayment, coinsurance, visit limitations i.e., sharing of outpatient benefits with acupuncture, chiropractic or occupational care, effective annual calendar renewal date, or any pre-authorization requirements.

TAG Physical Therapy cannot assume responsibility for incorrect information provided to us concerning your insurance policy. Our courtesy verification of eligibility and benefits does not guarantee that your insurance company will pay for all services provided. Your insurance policy is a contract between you and your insurance company. You are responsible for knowing your level of coverage and are ultimately responsible for the full payment of your bill.

CANCELLATION POLICY: Therapist time is reserved for your appointment – if you are unable to keep your appointment we kindly ask that you provide us with 24-hour advance notice of cancellation. If you fail to cancel a scheduled appointment 24 hours in advance, or “no-show” an appointment, we reserve the right to assess a \$50.00 cancellation fee.

I have read and understand the above TAG Physical Therapy Financial Policy, agree to the terms, and understand that I am ultimately responsible for payment of the health care services provided.

Printed Patient Name

Printed Name of Guarantor (if applicable)

Signature of Patient (or Guarantor)

Date



TAG Physical Therapy Office Policies

Consent for Care and Treatment: I, the undersigned, do hereby agree and give my consent for TAG Physical Therapy to provide physical therapy care and treatment necessary and proper in evaluating and treating my physical condition.

Consent for Treatment of a Minor: As parent and/or legal guardian, I authorize TAG Physical Therapy to treat the minor patient named in the attached consent form while I am not present.

Benefit Assignment/Release of Information: I hereby assign all medical benefits to which I am responsible to TAG Physical Therapy. I hereby authorize TAG Physical Therapy to release all information necessary, including medical records, to secure payment.

Workers' Compensation Claims: If I claim Workers' Compensation benefits and am subsequently denied such benefits, I may be held responsible for the total amount of charges for services rendered

Patient Signature

Date



TAG PHYSICAL THERAPY

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

TAG PHYSICAL THERAPY'S LEGAL DUTY

TAG Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

TAG Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, TAG Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

TAG Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, TAG Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop further disclosures at any time.

TAG Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. TAG Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that TAG Physical Therapy may have violated your privacy rights or if you disagree with any decisions we

have made regarding access or disclosure of your personal health information, please contact our owner(s) at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on TAG Physical Therapy's health information practices, or if you have a complaint, please contact the following:

TAG PHYSICAL THERAPY
111 Penn Street, El Segundo, CA 90245
CATHY TARTE or MINDY GARVEY
(310) 426-9570 (310) 426-9572 Fax
May 1, 2006



PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand TAG Physical Therapy's Notice of Information Practices. I understand that TAG Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that if I notify the practice, I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations. I also understand that TAG Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in TAG Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time

Patient Name

Signature

Signature of Parent/Guardian
(If patient is a minor)

Date