Allied Rehab
Speech, Occupational & Physical Therapy

900 S. Franklin Street, Suite #201
Wake Forest, NC 27587
(Corner of Hwy 98-Bypass & S. Franklin Street)

Office: 919-556-1700
Fax: 919-556-1245

www.AlliedRehab.net

Pediatric Registration Information **(Page 1)**

Date _____

Patient name _____

Date of birth _____Current age ___years ___months Gender F☒ M☐

Caregiver's Name _____ Relationship to Child _____

Mailing Address _____

City _____ State _____ Zip Code _____

Phone Number(s): Home _____ Cell _____

E-mail Address _____

Insurance _____ Policy # _____

Name of Policy Holder _____ Date of Birth _____

Primary Care Practice Name _____

Physician _____ Phone Number _____

Has your child ever received therapy services? Yes ☐ No ☐

If so, what services (ST, OT, PT, behavioral), where, and for how long? _____

_____

_____

Birth weight _____ Full term ☐ or Premature ☐ If so, how many weeks early? _____

How did you hear about us? _____

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Pediatric Registration Information (Page 2)

Name _____

Any birth complications? Yes ☐ No ☐
Required oxygen? Yes ☐ No ☐ Intubated? Yes ☐ No ☐
NICU stay? Yes ☐ No ☐ If yes, how long? _____
Other birth complications? _____
Has any illness, injury, or accident occurred that may have impacted your child's development? If so, please explain what and when _____
_____

Date of last hearing screening _____ Results _____
Does your child have frequent ear infections? Yes ☐ No ☐ If yes, how often? _____
Does your child have ear tubes? Yes ☐ No ☐ If yes, when were they placed? _____

Does your child have the following medical diagnoses?

☐ Abdominal/Stomach Issues
☐ ADD
☐ ADHD
☐ Asthma
☐ Autism
☐ Behavioral/Emotional Disorders
☐ Breathing Problems
☐ Cerebral Palsy
☐ Congenital Heart Disease
☐ Diabetes Type___
☐ Digestive Issues
☐ Down Syndrome
☐ Excessive Fatigue
☐ Head Injury/Concussion
☐ Hearing Loss
☐ High Blood Pressure
☐ Muscular/Skeletal Conditions
☐ Reflux
☐ Seizures
☐ Sleep Disorders
☐ Vision Problems/Glasses

Please list details AND any other medical conditions not mentioned above:
_____
_____

Does your child have any allergies? Yes ☐ No ☐ If yes, please list _____
_____

Has your child been hospitalized? Yes ☐ No ☐
Has your child had any surgeries or procedures? Yes ☐ No ☐ If yes, please explain
Date _____ Reason _____
Date _____ Reason _____

Current medications _____
_____

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Policies of Allied Rehab (Page 3)

Treatment Consent
I consent to therapy considered necessary in diagnosing and/or treating my condition.

Authorization and Release
I authorize Allied Rehab to bill and receive payments from my insurance company. I also permit the release of necessary information, including medical records, to my insurance company.

Financial Policy
Payment of all copays, deductibles, and any portion not covered by my insurance company is due at time of service. ALLIED REHAB WILL BILL MY INSURANCE COMPANY AS A COURTESY TO ME. Allied Rehab CANNOT guarantee insurance benefits given by the insurance company to be 100% accurate. The information Allied Rehab receives IS NOT A GUARANTEE of payment from your insurance company. It is recommended that I call and verify benefits prior to my scheduled appointment. I understand that I am responsible for any portion not covered by my insurance company and prompt payment is required. An 8% interest fee will incur on any balance greater than 30 days. Accounts sent to collections will incur additional fees.

No-Show Policy
A no show is defined as not showing up for your appointment OR failing to cancel within 24 hours of the scheduled appointment.
1st No-Show is a "warning" and note is made on your account
2nd No-Show, a $50 No-Show fee is charged and a notice to discharge at your next No-Show
3rd No-Show, another $50 No-Show fee is charged and Discharge from therapy.

Being on time for appointments is IMPERATIVE! The Therapist has blocked this time especially for me. Not showing up or giving less than 24 hours notice to cancel takes time away from other patients who would have benefitted from this appointment.

PLEASE INITIAL THAT YOU HAVE READ OUR POLICY ABOUT THE $50 NO-SHOW FEE _____

I have read, understood, and accepted the above policies as indicated by my signature below.

Name _____

Signature _____

Witness _____ Date _____

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Patient Information Consent Form

Verification of Notice of Privacy Practices (Page 4)

I have read and fully understand Allied Rehab's current "**Notice of Privacy Practices**".

I understand that Allied Rehab may use or disclose my personal health information (PHI) 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 I have the right to restrict how my PHI is used and disclosed for treatment, payment, and administrative operation if I notify the practice. I also understand that Allied Rehab 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 PHI for purposes as noted in Allied Rehab's "**Notice of Privacy Practices**". I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Signature Date

_____

Print Name