STONE OAK THERAPY SERVICES & LEARNING INSTITUTE

1020 Central Parkway South, San Antonio, TX 78232 Phone (210) 798-CARE Fax (210) 495-1479
Email address home@stoneoaktherapy.com Website www.stoneoaktherapy.com

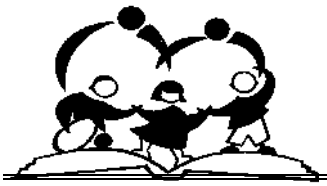
Physical Therapy Intake Form-Developmental

Patient's Name:			
SSN:	**Sex: (circle one)**	**M F**	**DOB:**
Parent / Legal Guardian Name(s):			
Address:			
Home Phone:	**Work / Alternate Phone:**		**E-mail:**
Emergency Contact:			
Relationship to patient:		**Emergency Contact #:**	
Primary Insurance:		**Policy #:**	
Policy Holder:		**Group #:**	
Policy Holder DOB:		**Policy Holder SSN:**	
Relationship to patient:			
Primary Care / Referring Physician:			
MD phone #:		**MD fax #:**	

Reason for Referral:_____

Other diagnoses: _____

 Patient's Last Name: _____ DOB: _____



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CONSENT TO TREATMENT AND RELEASE OF INFORMATION

I authorize the staff of Stone Oak Therapy Services to:

1. Administer and perform those treatments that have been prescribed by my or by my child's physician.
2. Release pertinent medical information to my/my child's physician, referring agency, or insurer and others as may be required.
3. Request and obtain medical information from my/my child's physician and other health care professionals as necessary to provide quality therapy services.

Printed Name of Patient

Printed Name of Responsible Party **Relationship to Patient**

Signature of Responsible Party **Date**

Terms of Service and Payment Agreement

INSURED PATIENT:

I authorize Stone Oak Therapy Services to submit claims for services rendered to my insurance carrier or third party payer, and I request payment for these services be made directly to Stone Oak Therapy Services or its designee.I understand that some services may not be covered by my insurance plan, or may be reimbursed at a much lower rate than what is usual and customary for this area. I further understand that I am responsible for any and all charges for services rendered that are not paid by my insurance carrier. This includes any fees incurred by Stone Oak Therapy Services in the event that my account must be forwarded to a collection agency due to non-payment.

ALL REQUIRED PAYMENTS ARE DUE AT THE TIME OF SERVICE.

Full payment at the time of service will be required. If Stone Oak Therapy Services is unable to bill my carrier directly, an invoice will be provided for me to submit to my carrier for reimbursement.

PRIVATE PAY PATIENT:

I accept responsibility for any and all charges for services provided to me/my child by Stone Oak Therapy Services. This includes any fees incurred by Stone Oak Therapy Services in the event that my account must be forwarded to a collection agency due to non-payment.
Full payment is due at the time of service/as indicated on statements sent to me by Stone Oak Therapy Services. My account will be considered delinquent if payment is not received within ten days of the payment due date listed on my statement. I understand that therapy services may be discontinued if my account becomes delinquent.

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the Stone Oak Therapy Services and Learning Institute's ***NOTICE OF PRIVACY PRACTICES***, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal or my child's personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Parent or Guardian of Patient Date Relationship to Patient

Printed Name:_____ _____

IF PARENT OR GUARDIAN OF PATIENT REFUSES TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW.

( ) Parent or Guardian of Patient refused to sign this Acknowledgement.

Print Name_____Date_____

Employee Printed Name and Signature:

_____

RELEASE AND WAIVER OF LIABILITY

ASSUMPTION OF RISK AND INDEMNITY AGREEMENT

In consideration of me or my child receiving services at Stone Oak Therapy Services and Learning Institute, the undersigned (representing all parties affiliated with the patient and/or student), in full recognition and appreciation of the dangers and risks inherent in such therapeutic activities associated with helping children with cognitive and/or physically disabilities, do hereby waive, release, and forever discharge Stone Oak Therapy Services and Learning Institute, its parent and affiliate organizations, its officers, agents and employees from and against all claims, demands, action or causes of action for costs, expenses or damages to personal property or personal injury, or death which may result from such participation in these activities.

The undersigned also acknowledges that injuries received may be compounded or increased by negligent rescue operations or procedures. This waiver of liability extends to any rescue operations performed by the staff on the premises or on route to an emergency medical facility.

The undersigned affirms that all health information pertaining to the patient and/or student has been divulged prior to services being rendered. The undersigned acknowledges that s/he retains general medical/health insurance to cover any such accidents in the event they do occur.

This waiver is intended to be as broad and inclusive as is permitted by law and that if any portion is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

I have read this release and waiver of liability, assumption or risk and indemnity agreement, fully understand its terms, understand that I have given up substantial rights by signing it, and have signed it freely and voluntarily without any inducement, assurance, or guarantee being made to me and intend my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

_____ _____

Patient or Student's Name Parent's Name Date

Patient's Last Name: _____ DOB: _____

Health History

Birth History

☐ Biological child ☐ Adopted ☐ Foster Child

Born at _____weeks gestation via ☐ Vaginal Delivery ☐ forceps ☐ c-section ☐ vacuum extraction

Postpartum complications? ☐ No ☐ Yes (describe): _____

Is your child currently under the care of a primary healthcare provider (PCP)? ☐ Yes ☐ No

Name of healthcare provider(s):_____

PCP Contact Infomation:_____

Other Physicians currently being seen:_____

May I exchange information when necessary with this provider? ☐ Yes ☐ No

Developmental History

Please list the age at which skill was first observed:

Gross Motor Milestone:	Age:	Comments / Concerns regarding gross motor skill:
Rolling Over		
Sitting Independently		
Creeping / Crawling		
Pulling to Stand		

Cruising		
Walking		
Running		
Jumping		

In my opinion, my child is developing:

☐ like an average child for his/her age in all areas of development.

☐ differently than an average child his/her age in any area of development

Therapy History

Please list all previous therapy received:

Type of therapy: _____ Dates performed: _____

Type of therapy: _____ Dates performed: _____

Type of therapy: _____ Dates performed: _____

Type of therapy: _____ Dates performed: _____

Please list all adaptive equipment used, e.g. wheelchair: _____

_____

_____

Medications

Name of Medication:	Dosage:	Reason for taking:

Please list any and all drug / food allergies: _____

_____

_____

Past Medical History

Please list any injuries, hospitilizations, surgeries or other medical interventions here as well.

Current	Previous	Condition	Explanation
☐	☐	Skin: e.g. rash, topical allergy, eczema	
☐	☐	Muscle: e.g., strain, tendonitis, hyper/hypotonia	
☐	☐	Joints: e.g. arthritis, fractures, contractures	
☐	☐	Nervous system: e.g. stroke, brain injury, shingles	
☐	☐	Respiratory: e.g. chronic lung disorders	
☐	☐	Cardiac / Circulatory: e.g. cardiac defects	
☐	☐		

		Digestive / GI: e.g. constipation	
☐	☐	Chronic health conditions	

Other special medical concerns / needs: _____

Family / Caretaker Goals

Please check all areas which are goals for your child:

☐ Increase range of motion (ROM)
☐ Increase strength
☐ Decrease pain
☐ Decrease fatigue
☐ Diminish developmental delay
☐ Improve functional mobility, e.g. ↑↓ stairs
☐ Improve gait (walking pattern)
☐ Improve balance
☐ Improve coordination
☐ Improve quality of life

Other goals? _____

_____

_____

I attest that the aforementioned is complete and accurate to the best of my knowledge.

Patient / Legal Guardian Signature: _____