Youthful Horizons
Therapy for Children & Adults

Pediatric Patient Form

Patient Identification

Patient's Last Name	First	Gender	DOB	Age

Home Address	City	State	Zip

Primary Care Physician	Additional Provider

Contact Information

Please provide names and the **BEST** possible phone number(s) and email. Be sure to notify us immediately of any changes. Please **CIRCLE** the email or phone that is the best way to reach you.

Parent(s)/Legal Guardian(s) Name(s)

1._____ Email_____

Phone #_____ Phone # _____

2._____ Email_____

Phone #_____ Phone # _____

Caregiver(s) Name(s) *People who might bring your child to therapy*

Name	Relationship	Phone Number

Name	Relationship	Phone Number

Emergency Contact Information:

Emergency Contact_____ Relationship_____

Emergency Phone Number_____ Phone Number 2 _____

Insurance: *Copy of insurance card/coupon is required*

Primary Insurance _____ Policy Number_____

Group No._____ Effective Date _____ Policy Holder's Name_____

Secondary Insurance_____ Policy Number_____

Group No._____ Effective Date _____ Policy Holder's Name_____

Authorization/Consent Form

Patient Name_____

Authorization for Treatment

I consent to the treatment necessary for the above named patient, including physical therapy, occupational therapy, speech therapy, aquatic therapy, massage therapy, and/or any other related services that the provider or physician advise to be necessary.

HIPPA Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews. I have been informed that I may review the practice/clinic's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent. I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic. I understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my request restriction, they must follow the restriction(s). I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Restrictions

_____

_____

_____

Individuals Allowed Access

_____

_____

_____

Cancellation/No-Show Policy – Please call 24 hours in advance to cancel.

We will send you a warning letter regarding your potential discharge after your 2nd missed visit. If there are 3 missed visits in a one-month period, you will be discharged from therapy. A letter will be sent to your primary care physician (PCP) explaining the reason for the discharge from our services. This will potentially cause a loss of your preferred time slot. In order to resume services you will need to obtain a new referral from your PCP and reschedule. We do understand there are special circumstances that can occur and we will review those carefully before making our final decision.

Payment/Insurance Authorization

I authorize for all insurance payments to be made directly to Youthful Horizons Physical Therapy, P.S. for therapy services rendered. I acknowledge that I am financially responsible for all charges not covered by this assignment. I further acknowledge that my insurance company may limit therapy benefits. I will be responsible for all charges accrued if DSHS, Healthy Options Coupon or my insurance denies service. Thank you!

I have read and fully understand the above consent for treatment, release of medical information, and payment/insurance authorization. I have fully read and agree to the cancellation/ no-show policy as described above.

I request that payment under the medical insurance program be made to the provider named below on any bills for services furnished to me. I authorize the below-named provider to release to the Social Security Administration, its intermediaries or carrier's information needed for the claim or any related Medicare Claim. I acknowledge that I have read and understand the Medicare Authorization. I further permit a copy of this authorization to be used in place of the original.

Provider's Name: Youthful Horizons Physical Therapy, P.S.
Provider's Address: 325 S. University Rd., Spokane Valley, WA 99206

_____
Please Print (Patient or Parent/Guardian)

_____
Signature (Patient or Parent/Guardian) Date

If signed by Patient representative, state relationship to patient_____

Pediatric Patient History

Child's Name_____ Date of Birth_____

Diagnosis _____

Reason for Referral _____ Today's Date_____

Birth History

☐ Full Term

Premature # of weeks_____

Drug/Alcohol use during pregnancy_____

Complications during pregnancy – details_____

Complications during delivery – details_____

Health concerns noted at birth – details_____

Medical History

Please list any hospital stays or surgeries including approximate ages:

_____

_____

_____

Current or ongoing health concerns:

_____

_____

_____

Special tests or screenings_____

Precautions or special medical needs_____

Current medications_____

Current allergies_____

Hearing status_____

History of ear infections ☐ Yes ☐ No ☐ Ear Tubes Date, if yes _____

Developmental History

Please list approximate ages when child achieved these skills:

_____ Sitting

_____ Crawling

_____ Walking

_____ First Words

_____ Finger Feeding

_____ Drinking from an Opened Cup

_____ Toilet Trained

_____ Responding to Name

Pediatric Patient History

(continued)

Services

Name of current school_____ Grade_____

Please describe past services, private or school:

Speech/Language Therapy_____

Physical Therapy_____

Occupational Therapy_____

What are your specific concerns about your child's development?

Please write any additional information you would like us to know:

Authorization to Release Medical Records

Records to be Released From/To

Business Name: **Youthful Horizons Physical Therapy**

Address: **325 South University Road**

City, State, Zip: **Spokane Valley, Washington 99206**

Records to be Released To/From

Business Name_____

Address_____

City, State, Zip_____

Patient Information

Patient Name_____

Address_____

City, State, Zip_____

Date of Birth_____ Phone Number_____

Social Security Number_____

I understand that:

1. I may revoke this authorization at any time in writing, except to the extent that action has been taken based upon it;
2. The recipient of these records may further disclose this information and it may then no longer be protected by federal privacy regulations;
3. I am entitled to a copy of this document;
4. I may refuse to sign this authorization and my refusal to sign will not affect treatment, payment, enrollment, or eligibility for benefits;
5. There may be a charge for the release of these records pursuant to 45 CFR 164.524 (c) (4) (HIPAA);
6. This authorization shall expire upon my written request to revoke or according to state law;
7 A copy of this authorization is valid as the original.

_____

Signature of Patient or Patient Representative Date

_____

Description of Representative's Authority to Act for Patient

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Dear Family,

Welcome to Youthful Horizons!

The Infant Toddler Network is part of the Children with Special Health Care Needs Program at the Spokane Regional Health District. Through this program, family resources coordination services are available to families of infants and toddlers, under the age of 3, who are receiving early intervention services such as physical, occupational, or speech therapy. The Infant Toddler Network also provides payment of early intervention services, if no other funding source is available.

Family Resources Coordinators (FRC) work collaboratively with Youthful Horizons to assure the best services for your family. Please sign below so that you child's evaluation and family contact information can be sent to the Infant Toddler Network. An FRC will be contacting you in the near future. Thank You.

Child's Name:_____ Date of Birth: _____

Parent/Guardian Name(s): _____

Address:_____ Phone:_____

City:_____ County:_____ State:_____ Zip: _____

Signature of Parent(s)/Guardian(s): _____ Date: _____

ITN/FRC Consent Form

INFANT TODDLER NETWORK (509) 324-1651
Fax: (509) 324-1699
Adapted logo courtesy of Department of Social & Health Services,
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