West Monroe: 107 Summer Lane West Monroe, LA 71291 PH: 318.396.1969 F: 318.396.1970
Ruston: 2309 S. Service Rd. W. Ruston, LA 71270 PH: 318.232.1969 F: 318.232.1970
Monroe: 4401 Sterlington Rd. Monroe, LA 71203 PH: 318.388.1989 F: 318.388.1992
Shreveport: 1800 Buckner Square -Ste C249 Shreveport, LA 71101 PH: 318.934.1969 F: 318.934.1960

Our mission: To joyfully use our gifts to brighten the lives of others.

Pediatric Patient Intake Form

PATIENT INFORMATION

Last Name:______________________First Name:__________________Middle:______________
Preferred name:__________________DOB:_____/_____/________Age:_________Gender: ☐ M ☐ F

Parent/Guardian/Caregiver Information

Parent/Legal Guardian:__________________DOB:_____ / _____ /________SSN:______________
If you are a guardian, please specify your relationship to the above patient:____________________
Address: ____
____

Please check if it is okay to leave a message.
Home:________________________________ ☐ Yes ☐ No
Cell:________________________________ ☐ Yes ☐ No
Work:________________________________ ☐ Yes ☐ No
Email:________________________________
Emergency Contact Name:__________________ Phone: ____________________

Additional Family Information

Select who may bring or pick up your child from therapy.
Father:______________________________ Phone #: ____________________
Mother:______________________________ Phone #: ____________________
Stepfather:___________________________ Phone #: ____________________
Stepmother:__________________________ Phone #: ____________________
Caretaker: ___________________________ Phone #: ____________________

Communication of Health Information

I permit ***Melanie Massey Physical Therapy*** to disclose and discuss any information related to my medical condition(s) with the following individuals:
Name:______________________________ Relationship:____________________
Name:______________________________ Relationship:____________________
Name:______________________________ Relationship: ____________________

Photo Permission

☐ Yes ☐ No I permit photograph/videotape of my child for treatment, education & documentation.
☐ Yes ☐ No I permit photograph/videotape of my child to be used for advertising, brochure & social media.

INSURANCE INFORMATION

Primary Insurance Carrier

Subscriber's Name: ______________________ DOB:_____/_____/ ________
Member's ID Number: ____________________ Group #: ____________________
SSN: ______________________________
Patient's Relationship to Subscriber: ☐ Self ☐ Parent ☐ Other

Secondary Insurance Carrier

Subscriber's Name: ______________________ DOB:_____/_____/ ________
Member's ID Number: ____________________ Group #: ____________________
Subscribers SSN: _________________________
Patient's Relationship to Subscriber: ☐ Self ☐ Parent ☐ Other

CLINIC POLICIES

Financial Policy

Thank you for choosing ***Melanie Massey Physical Therapy*** as your therapy provider. We are committed to providing the best possible care for you. To achieve this goal, we need your assistance in understanding our payment policy. Please understand that payment of your bills is considered part of your treatment. The following is a statement of our Financial Policy. Please read and sign before your treatment. Payment of services is due before or upon completion of each treatment visit. We accept ***CASH, MASTERCARD, VISA, DISCOVER***, ***CARECREDIT, and PERSONAL CHECKS***. Once your complete insurance information is on file, we will be happy ***to submit your claims to your insurance company.***

Sick/Cancellations/No Show Policy

To provide a safe and "well" environment for all the patients and staff, we require your child to be free from fever and vomiting for 24 hours.

No-show is someone who misses their appointments without canceling. Our front desk staff will attempt to call and reschedule, but if they are unsuccessful attempts to make-up or reschedule after three no-shows, we will remove your child from our reoccurring appointment schedule. We will be happy to assist you with any available appointments.

Waiting Room

To best address everyone's needs, parents and family members are asked to remain in the waiting room area unless otherwise requested by your therapist. If you would like to leave during your child's treatment, please provide adequate contact numbers to the front desk staff to reach you if any problems should occur during therapy. Please let our front desk staff know if you need to schedule a meeting to talk about your child's plan of care.

Divorced/Separated Parents

Melanie Massey Physical Therapy is dedicated to our patients and providing quality Physical, Occupational, and Speech Therapy care to your child (ren). Children of divorced or separated parents sometimes present our practice with unique challenges; therefore, the following policy has been established to avoid misunderstandings going forward.

Please read and agree to the following so that we may provide care to your child(ren).

- The providers and office staff will not be put in the middle of domestic issues or disagreements over the phone or in the office.
- Please make decisions regarding appointments and any office procedures before visiting our practice.
- "Joint Custody" means that each parent has equal access to the child's medicalrecords. Without a court order, we will not stop either parent from looking at their child's chart or obtaining test results. If there is a dispute between the parents regarding custody and a custody agreement has been reached, we will need to see documentation specifying the legal guardian.
- Only in situations where there is a confirmed, documented **Court Order** will one of the parents be denied access to the minor child's health records or visits at the office.
- Melanie Massey Physical Therapy must have a copy of this Court Order on file in the minor child's electronic chart.
- If there is NOT a court order on file with our office, either parent or legal guardian can sign a "Consent to Treat" form that authorizes any named individuals (like grandparents, nannies, etc.) to bring your child to our practice, be present during the visit and consent to any treatment during that visit. We will not be involved in any disputes regarding named individuals on the consent forms unless instructed by the court. Either parent or legal guardian can schedule an appointment for their child, be present for a visit, and obtain a copy of the visit summary. It is both parents' responsibility to communicate with each other about the patients' care, office visit dates, and any other pertinent information relevant to the patient. It is not the responsibility of the provider to communicate visit information to each custodial parent separately. Our providers will not call the non-attending parent the following visits. **Additionally, we will not call a parent to notify of an appointment scheduled by the other.**
- The responsibility of the bill for minors is with the parents or legal guardians. It is our policy to collect payment at the time of service from the parent, guardian, orcaretaker who brings the child in for

the appointment.
- The parent or guardian who completes the information sheet and signs the assignment and release **will be the guarantor** regardless of insurance coverage unless payment arrangements have been set up with billing before the visit.
- Should the issues that come between parents become disruptive to our organization or there is non-compliance with this policy, we reserve the right to discharge the family from the practice.

Consent to Treat
- **CONSENT TO TREATMENT**: I consent to rehabilitation and related services at ***Melanie Massey Physical Therapy***. In doing so, I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touching, and direct contact of a sensitive nature.
- **TREATMENT OF MINORS**: I, as parent/guardian of a minor receiving treatment hereunder, do agree and understand that I have been advised of ***Melanie Massey Physical Therapy's*** waiting room policies and treatment.
- **LIABILITY**: I know and agree that ***Melanie Massey Physical Therapy*** is not responsible for loss or damage to personal valuables.
- **WAIVER AND RELEASE**: I hereby release, discharge and acquit ***Melanie Massey Physical Therapy***, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.
- **AUTHORIZATION OF PAYMENT**: I assign all benefits directly to ***Melanie Massey Physical Therapy*** and also authorize any medical records necessary to facilitate my treatment process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

Disclosure Authorization for Release of Protected Health Information (PHI)
I have read and fully understand **Melanie Massey Physical Therapy** Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available in the front waiting area, or a hard copy may be obtained upon request. I understand that **Melanie Massey Physical Therapy** may use or disclose my personal health information for carrying out treatment, collecting 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 personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice.

I consent to the use and disclosure of my personal health information for purposes as noted in **Melanie Massey Physical Therapy** Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Agreement
I have read and agree to all of the above (Consent to Treat, Financial Agreement, Notice of Privacy Policy, Communication Policy, Photo Policy, Sick &No-Show Policy, Waiting Room Policy and Divorced/Separated Parent Policy).

Patient/Guardian Signature: ______________________________ Date:_____/_____/__________
Patient/Guardian Print: ______________________________
Witness Signature: ______________________________ Date:_____/_____/ __________