HISTORY AND INFORMATION FORM

Child's Name __________________________Child's DOB______ Sex ___ Home Phone ___________

Mother's Name________________________ Mother's DOB____________ Cell Phone _____________

Father's Name ________________________ Father's DOB _____________ Cell Phone _____________

Family's Address ____ City __________ Zip ____________

Mother's Occupation ____________________________ Work Phone ____________________________

Father's Occupation _____________________________ Work Phone ____________________________

Child's School/Daycare ____________________________ Child's Diagnosis ______________________

Referring Physician _______________________________ Physician's Phone ______________________

Physician's Address ____

Insurance Company ________________________ Policy Number ___________ Group Number ________

Name of policy holder ________________________________ DOB of policy Holder ________________

Is your child covered under another policy? _____yes ______no

Siblings, ages ____

Date of last Physical Therapy Evaluation _____________Are your child's immunizations up to date? ____

Does your child have any known allergies? _____ If yes, please specify ____________________________

Was your child born prematurely? If so, at what gestational age was he/she born? ____________________

Was the child required to stay in the NICU following birth? If so, for what reason and how long? ________

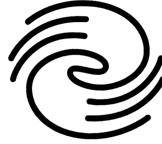
____

What would you like your child to accomplish as a result of receiving physical therapy ? ______________

____

Is there anything else your therapist should know that might assist her in working with your child? ______

____



KALE
DEMENT
PHYSICAL THERAPY INC

Consent For Therapy

I, ____, acting on behalf of

____ (hereinafter referred to as “the patient”)

Consent to the necessary care and/or treatment of the patient by the therapists doing business for Kale DeMent Physical Therapy, Inc. I consent to care and treatment that falls within the scope of physical therapy practice as defined by the state of Alabama and the American Physical Therapy Association. I understand that the practice of medicine, including physical therapy, is not an exact science and that the treatment will involve physical participation on the part of the patient which may involve risks of injury. I acknowledge that no guarantee has been made to me as the result of evaluation and/or treatment.

I consent to the taking and publishing of still or motion pictures of the patient’s diagnosis and/or treatment. I understand that the patient’s valuables and personal belongings are my responsibility and that Kale DeMent Physical Therapy, Inc. is not responsible or liable for any loss, theft, misplacement , or damage of personal belongings.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE CONTENTS AND AM COMPETENT TO EXECUTE IT OR IF EXECUTED ON BEHALF OF ANOTHER, I AM AUTHORIZED TO EXECUTE IT ON BEHALF OF THAT PERSON .

Signature of patient or person authorized to consent ____________________________ Date ___________

Relationship to patient _________________________________

Financial Agreement, Guarantee of Account

The undersigned agrees that in consideration of the services rendered to the patient, he/she hereby obligates himself/herself to promptly pay the account of Kale DeMent Physical Therapy, Inc. in accord with the regular rates and terms of the practice. I understand that physical therapy services are rendered and charged to the patient and not to the insurance company. Kale DeMent Physical therapy, Inc. cannot accept total responsibility for collection for your claim nor for negotiating a disputed settlement.

I agree to be responsible for all deductibles, coinsurance and non-covered portions of services performed.

Assignment of Insurance Benefits and Authorization to Release Information

I hereby authorize Kale DeMent Physical Therapy , Inc. to release information about this treatment/account to any person or corporation, including but not limited to, insurance carriers, welfare programs, or the patient's employer as necessary to secure timely payment.

I CERTIFY THAT I UNDERSTAND THE CONTENTS AND ACCEPT THE TERMS OF THIS FORM.

Guarantor Signature ________________________________ **Date** __________________

Relationship to Patient ________________________________