More Than A Gym
Pediatric Therapy & Play Gym

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New Patient Form

Patient Name:_____ Gender: M F

Date of Birth: _____ Age: _____ School: _____

Address: _____

_____

Email Address: _____

Home Phone: _____ Cell or Work: _____

Primary Care Physician: _____

Referring Provider: _____

Type of disability or developmental delay diagnosed with _____

Does the patient regularly use a brace, assistive device, or prosthetic? _____

Does the patient have any rashes, pressure sores, or any other skin conditions? _____

Does the patient have a hearing loss? Use hearing aids? _____

Does the patient have a history of ear infections and/ or tubes in their ears? _____

Does the patient have a visual impairment? Where glasses? _____

Does the patient use any special devices for bowel or bladder function? _____

Does the patient have muscle spasticity? Is it being managed medically? _____

Does the patient have a history of seizures? Is it being managed and how? _____

Does the patient have a history of any surgeries? _____

Does the patient have any allergies? _____

Has the patient previously been evaluated for PT/OT/ ST services? When? _____

Does the patient receive services through Early Intervention, CPSE or CSE? Services and frequency? _____

_____

Did the patient achieve their developmental milestones on time? _____

Around what age did the patient sit up? Crawl? Walk? _____

Please list any impairments or concerns: _____

_____

Please list any other important medical history:_____

_____

_____

Please list all medications currently taking: _____

Describe any behavioral challenges and plan currently adhering to: _____

List motor activities currently interested in _____

Who will be financially responsible for this patient's account?

Name:_____ Relationship_____ Date of Birth_____

Primary Insurance Company: _____

ID Number:_____ Group Number: _____

Claims Address: _____

Relationship with Insured: _____

Name of Insured: _____

Insured Date of Birth: _____

Insured's Address: _____

Insured Phone: _____

Secondary Insurance Company: _____

ID Number:_____ Group Number: _____

Claims Address: _____

Relationship with Insured: _____

Name of Insured: _____

Insured Date of Birth: _____

Insured's Address: _____

Insured Phone: _____

I verify the accuracy of any information given and authorize the release of any medical and demographic information necessary to process any claims. I understand that my insurance company will be sent an itemized bill for each session in accordance to reasonable and customary charges. I agree to assign benefits directly to More Than A Gym, LTD for all therapy services rendered. I also agree to remit any monies sent to me in error from my insurance company for services rendered to More Than A Gym, LTD. I agree to pay for all services rendered should my insurance company deny payment for services rendered, and will be responsible for any deductible, co-insurance or co-payment, to be paid at the time of my visit.

CANCELLATION/ DISCONTINUANCE FROM SERVICES POLICY

This office requires 24 hour notice for cancellations. Otherwise, you will be charged the full fee of the session. Should you miss three consecutive visits, it will be considered that you are not in compliance with your plan of care, and you may be discharged from this office.

I give permission for photographs/videos to be taken of myself or my child for educational, research, in order to monitor progress and/or marketing purposes.

_____ _____

Signature of Patient/Responsible Party Date