Sutherland Physical Therapy

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Valdosta, Georgia 31605
phone: (229) 244-1201
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Patient Information Form

Date: _____

First Name: _____ MI_____ Last Name_____

DOB: _____ Sex: ☐ Male ☐ Female

Parent/Guardian Names: _____

Address: _____City_____State_____Zip_____

Phone Number: _____Work Number: _____Cell Phone Number: _____

E-mail:_____ **Please circle preferred method of communication**

Diagnosis (if known):_____

Primary Physician: _____

Physician's Phone and Address: _____

Referring Physician (if different): _____

Other doctors and specialists who are involved in your child's care:

Name	Specialty	Phone Number

I give my permission for Sutherland Physical Therapy, INC, to exchange medical information about my child, _____ with the preceding healthcare providers.

_____ _____

Signature Printed Name

How did you hear about Sutherland Physical Therapy, INC?

_____

Babies Can't Wait Information

Is your child enrolled in the Babies Can't Wait program? ☐ Yes ☐ No
Does your child receive physical therapy through the Babies Can't Wait program? ☐ Yes ☐ No
Does your child receive occupational therapy services through the Babies Can't Wait program? ☐ Yes ☐ No
Does your child receive speech therapy services through the Babies Can't Wait program? ☐ Yes ☐ No
Who is the service coordinator? _____

Are you interested in the Babies Can't Wait program? ☐ Yes ☐ No

No Show Policy

To ensure each patient receives the most accurate treatment plan available, Sutherland Physical Therapy reserves the right to remove a patient from the schedule if ***three consecutive appointments*** are missed without notifying the therapist prior to the appointment. If the patient would like to return to therapy, they are required to obtain an updated referral from their primary care physician.

Appointment Time Policy

To ensure each patient receives the necessary time reserved for their appointment, if you are ***more than 10 minutes late*** to your appointment, Sutherland Physical Therapy reserves the right to reschedule the patient's appointment. We understand circumstances arise. However, please notify us in a timely manner if you will not be on time.

Thank you,
Sutherland Physical Therapy

Patient Name _____

Signature (of Parent or Guardian) _____

Date _____

Insurance Information: ***If Private insurance, we must have the policy holder's DOB!***

Primary Insurance:_____ Name of Insured:_____

Insured SS #:_____ Member ID:_____ Group #_____

Claims Address (found on back of card):_____

Customer Service #:_____ Policy Holders DOB_____

Secondary Insurance:_____ Name of Insured:_____

Insured SS #:_____ Member ID:_____ Group #_____

Claims Address (found on back of card):_____

Customer Service #:_____ Policy Holders DOB_____

Medicaid Number:_____ Effective Date:_____

Family Background

Mother's Name: _____ Age: _____

Occupation _____

Father's Name: _____ Age: _____

Occupation _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Brother(s) and/or Sister(s) of the child:

Name	Age

What are your goals in coming to therapy?

_____

_____

_____

Has your child previously received therapy services? ☐ Yes ☐ No

If "Yes", where and when? _____

Medical History

At how many weeks was your child born? _____ Birth weight? _____ Birth Length?_____

Were there any complications during the pregnancy or delivery? ☐ Yes ☐ No Please describe: _____

_____

Was your child hospitalized after birth? _____

Does your child have any other medical issues? _____

_____

Does your child have a history of ear infections? ☐ Yes ☐ No Have PE tubes? ☐ Yes ☐ No

Please list any hospitalizations and/or medical procedures your child has received:

_____

_____

Current medications:

Name	Dosage	Frequency	Reason for medication

Any known allergies: ☐ Yes ☐ No. If yes, please describe:_____

_____

Are there any precautions or restrictions? _____

Has your child ever experienced or been diagnosed with a seizure disorder? _____

State ages for the following milestones if mastered:

Babbling _____
Stopped using bottle _____
Stopped using pacifier _____
Eating table foods _____

First words _____
Sitting independently_____
Walking independently _____
Crawling _____

Does your child drink from a sippy cup? _____ Open cup? _____

Does your child feed himself? _____ Use a spoon? _____

Does your child have trouble with certain textures of foods? _____

Education Information

Is your child currently enrolled in school? ☐ Yes ☐ No

If "Yes", where and days attended:_____

Does your child receive any services through the school? ☐ Yes ☐ No If "Yes", what services? _____

What days are services received at school? _____

Does your child have a current Individualized Education Plan (IEP)? ☐ Yes ☐ No

Social/Emotional History

Is your child currently enrolled in any community activities (music class, play groups, Mother's Morning Out Program)?_____

_____

_____

Anything else you would like to tell us about your child or family? _____

_____

_____

****Preferred time/day for therapy: _____

Times/Days that are not good for your child: _____

PERMISSION TO PHOTOGRAPH

I give my permission for the Therapists/Staff to create a photo likeness of my child to be used within the clinic, in research, or in publications. _____YES _____NO

I give permission for photo likeness of my child to be taken with the following conditions:

_____

_____ _____ _____

Name of Person Completing This Form | Relationship to Child | Date

PEDIATRIC OFFICE POLICIES

1. Consistent attendance is important to your child's progress in therapy. We ask that you respect our time by providing our office with 24 hour notice if you are unable to attend at your appointed date and time. A call the day of your appointment will be accepted in emergencies or illness, but please notify our office as soon as you know you are not going to make your scheduled appointment.

   _____ initials

2. If you have three consecutive "No Show" appointments or excessive cancelations, you will be taken off the schedule. You will then need to contact our office when you are ready to attend therapy sessions on a regular basis again.

   _____ initials

3. I further understand that it is my responsibility to inform Sutherland Physical Therapy, INC of any changes in my address, phone number or insurance immediately. Failure to do so could result in incorrect processing of insurance claims thus making me responsible for any unpaid claims.

   _____ initials

4. While we monitor authorization periods received from your insurance company and any state run program in which your child is enrolled, it is your responsibility to monitor the dates and advise us of those approaching expirations. Further, it is your responsibility to inform us if treatment authorizations are combined with other treatments that your child is receiving.

   _____ initials

5. I understand and agree I am required to stay on premises during the child's therapy session.

   _____ initials

I have read and fully understand the above stated policies. I have also received a copy of the HIPPA Notice of Privacy Practices.

_____ _____

Signature of parent or legal guardian Date

_____

Printed name of parent of legal guardian

_____ _____

Witness Signature Date

_____

Printed name of witness

EMERGENCY CONTACT NAME AND PHONE NUMBER:_____

_____