ONE POINT PHYSICAL THERAPY

867 Greenwood Ave NE
Atlanta, GA 30306
404-600-4627

GENERAL HISTORY INFORMATION

Child's Name:_____ DOB:_____ Sex: ☐M ☐F

Parent(s) Name: _____ Parent SSN: _____

Phone: _____ Work phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Email Address:_____

Would you like appointment reminders? ☐Yes ☐No If Yes; ☐Text ☐Email

How did you hear about us? ☐Doctor ☐Friend ☐Website ☐Attorney ☐Other_____

PEDIATRICIAN INFORMATION

Child's Pediatrician:_____ Phone:_____

Did your Pediatrician refer you? ☐Yes ☐No

If no, name of referring provider:_____ Phone:_____

Reason for Referral:_____ Child's age when problems first noticed:_____

Other physicians your child sees:_____ Specialty:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____

Home/Cell Phone:_____ Work Phone: _____

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INSURANCE INFORMATION

Insurance Company Name:_____ DOB of Guarantor:_____

Insured Party: ☐ Self ☐ Spouse ☐ Parent ☐ Employer ☐ Other

Secondary Insurance information (if applicable)

Secondary Insurance Name:_____ Phone Number: _____

PATIENT HISTORY

When did you first become concerned about your child's development: _____

Has your child received occupational, physical, or speech therapy in the past or is he/she currently receiving any of these services:_____

_____

Please indicate at what age each major milestone was reached (if applicable):

Sitting _____ Crawling_____ Walking_____ First word_____

School History of Child (if applicable) (Name of school/daycare, grade, etc): _____

Does your child have a current IFSP (individualized family service plan): ☐ Yes ☐ No

Does your child have siblings, please list names and ages: _____

MEDICAL HISTORY

Did the child's mother have any illnesses or complications during pregnancy or delivery? Please describe:

_____

Was your child premature: ☐Yes or ☐No

Born at how many weeks gestation?_____ Birth Weight_____

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Did your child require any medical procedures before, during, or after birth? Please describe: _____

_____

FEEDING

Did/does your child have any feeding problems as an infant? Please describe: _____

_____

Was/is your child bottle fed or breast fed and for how long: _____

Does your child have any colic or reflux issues: _____

HEARING

Has your child had any ear infections? (Please list number if known): _____

Has your child had their hearing tested? What were the results: _____

VISION

Does your child wear glasses or have any visual concerns:_____

ILLNESS

Does your child take any medications? Please list: _____

Does your child have any allergies? Please list:_____

Please describe illnesses, medical issues, or hospitalizations that your child has had and when they occurred: _____

_____

Please list current concerns/expectations/goals for your child at this time:_____

_____

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INSURANCE AND BENEFITS

I the undersigned certify that I (or my dependent), have insurance coverage with the above listed insurance company and assign directly to OnePoint Physical Therapy, Inc. all insurance benefits. I understand that I am financially responsible for all charges that are not payable by insurance. There will be a $30.00 returned check fee. **I understand that it is my responsibility to check with my insurance to see what my benefits will be and if my plan pays in or out of network. I realize that you have verified this, however, that is not a guarantee of benefits or payments**. I also authorize the release of my medical and billing information to my insurance company and Physician if requested to process this claim.

24-HOUR LATE CANCEL/NO SHOW POLICY

We have a 24-hour late cancellation/no show policy. If you fail to show up for your scheduled appointment you will be charged a $30.00 fee. Please call us 24 hours in advance to cancel/reschedule your appointment. Failure to do so will result in a $30.00 charge. This charge will be an out of pocket expense and cannot be billed to your insurance company.

INFORMED CONSENT TO TREAT MINORS

I consent to rehabilitation treatment for my child by OnePoint Physical Therapy. Further, I acknowledge that no guarantees have been made to me regarding treatment and the treatment results for my child from the rehabilitation therapy.

I have the right to ask questions about any potential risks with treatment and questions about my child's condition throughout the rehabilitation process. I accept the role of my child's participation in their recovery and I am aware that their physician will be kept informed as to the status of their recovery as well as their compliance with therapy and attendance. I understand that it is my responsibility to inform the physical therapist/staff about any changes in my child's health status, medications, or allergies that may affect treatment.

Parent/Guardian Signature: _____Date:_____

Parent/Guardian Name: _____

Patient Name:_____

Front Office Coordinator: _____Date: _____

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