Summit Physical Therapy & Rehab
PATIENT REGISTRATION

DATE: _____
REFERRING PHYSICIAN: _____
LAST NAME: _____ FIRST NAME: _____ MI: _____
PHYSICAL ADDRESS: _____
CITY_____ STATE _____ ZIP _____
E-MAIL ADDRESS: _____
MAILING ADDRESS: _____
CITY _____ STATE _____ ZIP _____
HOME # _____ CELL # _____ WORK # _____
DATE OF BIRTH: _____ SSN: _____
INSURANCE WE WILL BE BILLING: _____
EMPLOYERS NAME: _____
EMPLOYERS ADDRESS: _____
SPOUSES'S NAME/EMERGENCY CONTACT: _____
EMERGENCY CONTACT NUMBER: _____
SPOUSES'S EMPLOYER: _____
Phone # for appt reminder messages: _____ __Text __Voice

Below is an explanation of your benefits as provided by your insurance company. This is not a guarantee of your benefits as it is your responsibility to obtain your exact information. By signing below you are stating that you understand your benefits. **Any amounts not covered by your insurance will be billed to you upon completion of treatment.**

PLEASE INITIAL _____

DEDUCTIBLE: _____ AMOUNT MET: _____
CO-PAY: _____ COPAYS ARE DUE AT TIME OF SERVICE
CO-INSURANCE: _____
OUT-OF-POCKET MAXIMUM: _____ AMOUNT MET: _____
LIMITATIONS ON THERAPY SERVICES: _____
_____
_____

PATIENT RELEASE

I HEREBY AUTHORIZE SUMMIT PHYSICAL THERAPY & REHAB AND ITS AGENTS TO FURNISH ALL INFORMATION IT MAY HAVE REGARDING MY CONDITION, TREATMENT AND PROGRESS WHILE UNDER SUMMIT PHYSICAL THERAPY & REHAB'S OBSERVATION OR TREATMENT (INCLUDING THE HISTORY OBTAINED, PHYSICAL FINDINGS, AND PROGNOSIS) TO THE INSURANCE COMPANY OR ITS REPRESENTATIVES, MY EMPLOYER, MY PHYSICIAN, OR MY ATTORNEY UPON THEIR REQUEST OR DURING TREATMENT AND PROGRESS CONFERENCES. THIS AUTHORIZATION SHALL REMAIN VALID UNTIL REVOKED BY ME IN WRITING. ADDITIONALLY, I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO SUMMIT PHYSICAL THERAPY & REHAB FOR SERVICES RENDERED, AND FULLY ACCEPT TOTAL RESPONSIBILITY FOR ALL SERVICES NOT FULLY PAID FOR BY ANY INSURANCE COMPANY, AND/OR MEDICARE/MEDICAID.

PATIENT SIGNATURE _____ DATE _____
PARENT/GUARDING SIGNATURE: _____ DATE _____

Sean Cox, RPT/owner • Bret McGuire, DPT, RPT/owner
Kym Claborn, M.S., CCC-SLP, Clinic Manager

1071 W. Blue Starr Drive • Claremore, OK 74017
(918) 341-4343 • FAX (918) 341-8687
E-mail: pediatrictherapies@ptsummit.com

www.ptsummit.com

AUTHORIZATION TO REQUEST AND/OR RELEASE INFORMATION

Child's Name:_____ Parent/Legal Guardian:_____

Date of Birth:_____

Does your child receive any therapy services through Sooner Start or a Public School?_____

If yes, please indicate the school district in the RELEASE/RECEIVE INFORMATION sections as we will request an IEP or IFSP for 3rd party payment.

Does your child receive WIC services?_____

"INFORMATION" is considered but not limited to phone calls, conversations with individuals and copies of records that include medical testing, educational testing, psychological testing, diagnoses and treatment plans and progress.

Please list those people, agencies or medical facilities that we may RELEASE YOUR CHILD'S INFORMATION TO:

_____

_____

Please list those people, agencies or medical facilities that we may RECEIVE YOUR CHILD'S INFORMATION FROM:

_____

_____

This authorization expires on this date_____ or when my child is no longer receiving services from Summit Pediatric Therapies. At any time you may revoke this authorization. You must indicate your desire to do so in writing and submit to:
Summit Pediatric Therapies, 1071 Blue Starr Dr., Claremore, OK 74017

I confirm that I have reviewed this authorization form and agree with its statements. My signature below indicates my authorization for the release and receipt of personal health information of the minor child listed above.

Printed name:_____Signature:_____

Date:_____Relationship to Child:_____

NOTICE OF PRIVACY PRACTICES
Summit Physical Therapy and Rehab, Inc.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Summit Physical Therapy is required by law to protect certain aspects of your health care information known as Protected Health Information or PHI and to provide you with this Notice of Privacy Practices.

Uses and Disclosures of PHI: Summit Physical Therapy may use PHI for the following purposes:
1. For Treatment: Summit may use and disclose your PHI to doctors, nurses, technicians, or healthcare professionals caring for you.
2. For Payment : Summit may use and disclose your PHI to obtain reimbursement and determine eligibility.
3. For Healthcare Operations: Summit may use and disclose your PHI for operations such as employee evaluations, licensing, credentialing, and compliance activities.
4. For Emergency Notification: Summit may use and disclose your PHI to a family member or another person responsible for your care in the event of an emergency.
5. For Law Enforcement Purposes: Summit may use and disclose your PHI if we suspect you are a victim of abuse, neglect, or domestic violence. We may also use and disclose your PHI for national security, criminal and/or intelligence activities.
6. For Court Orders and Judicial Matters: Summit may use and disclose your PHI in response to subpoena, discovery request, court or administrative order, or other legal request.
7. For Public Health Purposes: Summit may use and disclose your PHI to public health authorities involved in the prevention or control of disease, injury, or disability.
8. For Workers Compensation: Summit may use and disclose your PHI in compliance with workers compensation laws.
9. For Health Oversight Purposes: Summit may use and disclose your PHI to entities providing health oversight, including audits, licensure or disciplinary actions, inspections, and other authorized activities.

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information based upon that authorization.

Patient Rights:
1. You have the right to access, copy or inspect your PHI. Summit will normally provide you with access to your PHI within 30 days of the request and we have the right to charge for copies made.
2. You have the right to amend your PHI. If errors are found we have 60 days to amend the PHI. Summit is permitted to deny your request to amend in certain circumstances.
3. You have the right to request an accounting of Summit's use and disclosure of your PHI. Summit is not required to give an account for uses and disclosures involving treatment, payment, when sharing your PHI with our staff, or for PHI which we have been given written authorization for.
4. You have the right to request additional restrictions or disclosures of your PHI. However, restrictions or disclosures will not be honored if emergency treatment is needed.

Questions or Complaints:
If you have any questions or complaints regarding this notice, Summit has a designated "Privacy Officer" whom you may contact. Simply ask to speak with Summit's "Privacy Officer", or address written correspondence to Summit Physical Therapy, Attn: Privacy Officer, 1071 W. Blue Starr Drive, Claremore, OK 74017. You may contact us at 918-342-3800. If you file a complaint against us, we will not retailiate in any way.

Patient Acknowledgement:
I have received Summit Physical Therapy & Rehab's Notice of Privacy Practices, and I have been given the opportunity to review it.
Patient Name (please print): _____ Date: _____
Signature: _____

STATE OF OKLAHOMA
Oklahoma Health Care Authority

Parental Consent Form

Member Name: _____
Member RID #: _____
Member Diagnosis: _____

I _____ (print name of parent/legal guardian) **hereby authorize** Summit Physical Therapy (print name of provider) **to evaluate, as well as provide any subsequent treatment based on the evaluation results for Physical Therapy, Occupational Therapy and/or Speech Therapy** (circle all services that apply) **for child named above.**

_____
Signature of Parent/Legal Guardian

_____
Date Signed by Parent/Legal Guardian

_____
Relationship to Member

_____
Signature of Therapist or Representative of Therapy Group

_____
Date Signed by Provider

******Please Note Form must be completed in its entirety or will be considered incomplete and will not be accepted******

Sean Cox, RPT/owner • Bret McGuire, DPT, RPT/owner
Kym Claborn, M.S., CCC-SLP, Clinic Manager

1071 W. Blue Starr Drive • Claremore, OK 74017
(918) 341-4343 • FAX (918) 341-8687
E-mail: pediatrictherapies@ptsummit.com

www.ptsummit.com

SUMMIT PEDIATRIC QUESTIONNAIRE

Name of Child: _____ DOB: _____
Referring Physician: _____

REFERRAL INFORMATION

I. Who referred you to this clinic? _____

What are the general concerns that you have for your child? (Please check all that apply)

( ) Fine Motor ( ) Gross Motor ( ) Sensory Processing ( ) Self-Care Skills

( ) Speech / Language ( ) Social/Emotional ( ) Getting Along With Others

( ) School Performance ( ) Cognition ( ) Behavior ( ) Attention

What are the specific concerns that prompted you or your doctor to seek therapy?

_____
_____
_____
_____

Please list your child's diagnoses (Developmental Delay, Autism, Torticollis, Sensory Processing Disorder, etc.):

_____
_____

II. FAMILY/SOCIAL HISTORY:

Please circle any of the below listed problems that may appear in the family history (close relatives) of the child:

Autism
Cerebral Palsy
Speech/Language Disorder
Learning Problems
Emotional Problems
Intellectual Disability
Pervasive Development Disorder
Seizure
Neurologic Problems
Attention Deficit Disorder
Attention Deficit Hyperactivity Disorder

Genetic Syndromes (please explain): _____
Other:

SUMMIT PEDIATRIC THERAPIES QUESTIONNAIRE
1071 W. Blue Starr Dr., Claremore, OK 74017
Phone: (918) 341-4343 Fax: (918) 341-8687

III. PREGNANCY AND BIRTH HISTORY

1. Birth weight: _____lbs. _____oz._____
2. Mother's age at the time of pregnancy: _____
   Father's age at the time of pregnancy: _____
3. Number of pregnancies of child's natural mother: _____
   Number of live births of child's natural mother: _____
   Which pregnancy is this child: _____
4. Prenatal care began: 1st trimester 2nd trimester 3rd trimester
5. Problems during Pregnancy

		Yes	No
a.	Bleeding/Spotting	___	___
b.	Injuries	___	___
c.	Diabetic state in pregnancy (sugar in urine)	___	___
d.	High blood pressure	___	___
e.	Infections	___	___
f.	Toxic exposure	___	___
g.	Preterm labor	___	___
h.	Maternal weight gain _____ lbs.	___	___

   i. Fetal activity (please circle):
   Normal Increased Decreased
6. During your pregnancy did you (child's mother) use: (Circle all that apply)

			If yes, please list	How often
Alcohol	yes	no	_____	_____
Tobacco	yes	no	_____	_____
Drugs	yes	no	_____	_____

7. Length of Pregnancy: _____ weeks
8. Labor: spontaneous induced
   How long was the labor? _____
9. Delivery (please circle): Vaginal Forceps/Vacuum Assisted Cesarean
   If Cesarean, why? _____
10. Did the baby require any oxygen, resuscitation or reviving after birth?
    Yes No
    If yes, why and how long? _____
    What were baby's Apgar scores? _____
11. Did the baby stay in intensive care? Yes No
    If yes how long? _____
12. Place of birth: _____Name of Hospital _____
13. Discharge from hospital at _____ days of life.

	YES	NO
Problems in the Nursery	___	___
Problems breathing	___	___
High or low blood sugar	___	___
Jaundice (yellow skin)	___	___
Bleeding in head	___	___
Feeding difficulties	___	___

Other:

_____

_____

IV. DEVELOPMENTAL HISTORY – Areas of Development

1. Speech/Language (talking, understanding, communicating with others)
   Do you think your child is functioning: BELOW AT ABOVE age level? (circle)

   At what age did your child: Say his/her first word? _____2-word phrase _____
   What age level does he/she seem to function? _____

   Do you have any concerns in this area? YES NO
   If yes, what are the concerns? _____

2. Motor Development (rolling over, sitting, walking, writing, buttoning, cutting)
   Do you think your child is functioning: BELOW AT ABOVE age level? (circle)

   At what age did your child crawl? _____
   At what age did your child walk? _____
   What age level does he/she seem to function? _____

   Do you have any concerns in this area? YES NO
   If yes, what are the concerns? _____

3. Cognitive (problem solving, following instructions, learning in school, intellectual abilities)
   Do you think your child is functioning: BELOW AT ABOVE age level? (circle)
   What age level does he/she seem to function? _____

   Do you have any concerns in this area? YES NO
   If yes, what are the concerns? _____

4. Social-emotional (expressing feelings, needs, getting along with others, attachment, behavior)
   Do you think your child is functioning: BELOW AT ABOVE age level? (circle)
   What age level does he/she seem to function? _____

   Do you have any concerns in this area? YES NO
   What are the concerns? _____

5. Areas of Developmental Milestones (eating, drinking, dressing, toileting)
   Do you think your child is functioning: BELOW AT ABOVE age level? (circle)

   At what age was your child toilet trained? Day_____ Night _____
   At what age was your child peddling a bike? _____
   Tying his/her shoes? _____Drinking from a cup? _____
   Feeding him/herself? _____Dressing him/herself? _____

6. Educational (learning to read and write, solve problems)
   Do you think your child is functioning: BELOW AT ABOVE age level? (circle)
   What grade level do you think your child is functioning: _____

   Do you have concerns in this area? YES NO
   If yes, what are your concerns? _____

SUMMIT PEDIATRIC THERAPIES QUESTIONNAIRE
1071 W. Blue Starr Dr., Claremore, OK 74017
Phone: (918) 341-4343 Fax: (918) 341-8687

V. HEALTH HISTORY (PAST MEDICAL HISTORY)

Physicians or specialists involved in your child's care: _____

_____

Please give details of any medical problems or hospitalizations for your child?

_____

_____

_____

Has your child required any surgeries? YES NO
Please explain:

_____

_____

_____

Has your child had any serious injuries, especially head injuries? YES NO
Please explain:

_____

_____

Is your child currently taking any prescription or non-prescription medications on a regular basis? YES NO
Please list medications: _____

_____

Does your child have any allergies to foods or medications? YES NO
Please explain. _____

_____

Diet: Does your child have any particular eating difficulties (gagging, choking on food, coughing during meals, or specific food preferences/taste/texture)?

_____

_____

_____

Is your child on a special diet? YES NO
Does your child use any other special treatments? (herbal supplements, biofeedback, etc)

_____

_____

VI. REVIEW OF SYSTEMS

Please check if your child has experienced any of the following:

Yes	No		Yes	No	
___	___	Seizures	___	___	Parental concerns about hearing
___	___	Staring episodes	___	___	Aspiration pneumonia
___	___	Motor or vocal tics	___	___	Asthma
___	___	Headaches	___	___	Sleep difficulties
___	___	Drooling	___	___	Previous MRI or CT Scan
___	___	Ear infections	___	___	Breathing difficulties
___	___	Chewing/Swallowing difficulties	___	___	Strabismus
___	___	Cup drinking difficulties	___	___	Wears glasses
___	___	Gagging			
___	___	Early Childhood Diseases (measles, chicken pox) please specify_____			

Previous vision screen/ophthalmologic assessment- When:_____

NORMAL ABNORMAL

Comments:_____

_____

Previous hearing screening/audiological assessment- When:_____

NORMAL ABNORMAL

Comments: _____

_____

VII. SCHOOL INFORMATION

1. Early Intervention.

Has your child ever received Early Intervention Services? YES NO

(please circle all that apply)

Sooner Start
Head Start
Preschool Developmental Delay Class

Services received: (please circle all that apply) Speech/Language Cognitive

Physical Therapy Occupational Therapy Child Development Specialist and Nursing

Other: _____

2. School Attended: Preschool _____
Kindergarten _____
First grade & up _____

3. Is there a current Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) in place? YES NO