COMMUNITY SPORTS & THERAPY CENTER

WEB www.cstcenter.com PHONE 419-678-OHIO

SERVING OUR COMMUNITY SINCE 1980

a proud partner of Mercer Health

New Pediatric Patient Intake Form

Name: ______________________ Date of Birth: ____________ Age: ____ Date: __________

Are you presently receiving ANY type of home health care services from ANY home health agency or hospice? Examples: Mercer Health Home Health or Celina Visiting Nurses ☐ Yes ☐ No

Have you received ANY other therapy services throughout the year from another therapy agency?
☐ Yes ☐ No

Are you currently being treated by another physician or health care practitioner (chiropractor, physical therapist, etc.)? ☐ Yes ☐ No If yes, who? ______________________

For what? ______________________

What diagnosis/injury has brought you to therapy? ______________________

____

When did it start? ______________________

What is your goal(s) to accomplish in therapy? ______________________

____

Birth History (Full-term, NICU, Apgar Score, Natural Birth Vs. C-Section)? ______________________

____

____

____

Current and Past Medical History *(Check all that apply.)*

☐ Anemia
☐ Angina/Chest Pain
☐ Arrhythmia
☐ Asthma/Emphysema/COPD
☐ Bleeding Disorder
☐ Blood Clots
☐ CAD (Coronary Heart Disease)
☐ Cancer
☐ Congenital Heart Defect
☐ Depression
☐ Diabetes
☐ Drug/Alcohol Abuse
☐ Fractures
☐ GERD
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/AIDS
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Kidney Disease
☐ Liver Disease
☐ Mental Health Issues
☐ MI/Heart Attack
☐ Migraines/Headaches
☐ Neurological Diseases
☐ Obstructive Sleep Apnea
☐ Renal Disease
☐ Seizures
☐ Sickle Cell
☐ Stroke/CVA/TIA
☐ Vascular Disease

If you checked any of the above, please explain: ______________________

____

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Patient Name: ______________________________ Date: ______________

List all surgeries: ____

____

Do you have any allergies? □ Yes □ No If yes, please list: ______________________________

____

If you are obtaining therapy without a physician referral, please list a physician in which we can share your therapy information/notes.

Physician: ______________________________

__Medicare Patients__ – in order to bill Medicare we require a physician referral due to physician certification and recertification requirements by Medicare.**

Please check any of the following treatments you have had in the past.

□ Physical therapy ________________ □ Psychologist ________________

□ Occupational therapy ________________ □ Chiropractor ________________

□ Pain program ________________ □ Nerve block ________________

□ Back school ________________ □ TENS ________________

□ Other ________________

Do you have any religious or cultural considerations we need to know about before you start our program?

□ Yes □ No If yes, please explain: ______________________________

____

____

Are you in a situation with someone who is physically, emotionally, or sexually hurting you? □ Yes □ No

Please feel free to ask our staff any questions you may have regarding our services or any billing/price information. We will be glad to assist you in any way we can.

<u>Several insurance companies require you to contact them before you receive therapy services. It is your responsibility to see that this is done but our staff will assist you as much as possible</u>. Insurance coverage varies from company to company. It is the patient's ultimate responsibility to verify insurance coverage for services received. Please note that we are a hospital-based facility, not a free-standing facility, and our billing at all locations is completed through Mercer Health hospital.

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Patient Name: ______________________________ Date: ______________

Our goal is to provide you with the highest quality professional service in an efficient manner. We have allocated sufficient time to properly meet your needs. If for any reason you cannot make your therapy appointment, please notify us at least 8 hours before the scheduled appointment. If you fail to do so, we reserve the right to charge a missed appointment charge that insurance usually does not cover.

We are a clinical education site for multiple universities and professional schools. There are times we have therapy students in our department. They may observe and at times perform your treatment program in aspects of your care that they have been determined to be competent in and with proper supervision. May we have your permission for students to perform and/or observe your treatment? If at any time you feel uncomfortable with this you may let us know and we will make other arrangements.

□ **Yes, students may perform, participate and/or observe my treatment with proper supervision.**
□ **Yes, students may observe and participate in my treatment, but not perform any treatment.**
□ **No, students may not perform, participate and/or observe my treatment.**

There are also volunteers in our department observing this field of the medical environment in further medical education. Volunteers by policy do not perform treatment in our department.
□ Yes, volunteers **may** observe my treatment.
□ No, volunteers **may not** observe my treatment.

How did you hear about us? *(Check all that apply.)*

□ Doctor □ Newspaper Ad □ Radio Ad □ Social Media

□ Friend/Relative □ Website/Internet □ Previous Experience

□ Other: ______________________________

Email Address: ______________________________

TO THE BEST OF MY KNOWLEDGE, INFORMATION PROVIDED HEREIN IS CORRECT.
I, the patient have also reviewed the Rehabilitative Services Department's Patient Bill of Rights and Responsibilities statement and I am committed to cooperating and participating at my fullest capacity. A copy of the hospital Patient Bill of Rights and Responsibilities (Policy #A-3) that addresses the rights and responsibilities of patients is also available upon request.

______________________________ ______________

Signature of Patient/Legal Guardian Date

Informed Consent for Physical, Occupational and Speech Therapy

Physical, occupational and speech therapy involve the use of many different types of physical examination and treatment. At Community Sports and Therapy Center we use a variety of procedures and modalities to help us attempt to improve your function. As with all forms of medical treatment, there are benefits and risks involved with therapy.

The physical response to a specific treatment can vary widely from person to person. It is not always possible to predict your response to a certain procedure or modality. We are not able to guarantee what your reaction will be to a particular treatment, nor can we guarantee that our treatment will help the condition you are seeking treatment for.

Benefits may include improvement in symptoms and overall function. You might also experience decreased pain and discomfort. You could also gain a greater knowledge about your condition and how to manage your condition.

Potential risks may include increase in current level of pain, aggravation of previously existing conditions, and could involve life threatening situations.

I understand that the physical therapist, occupational therapist and/or speech language pathologist provides a wide range of services. I acknowledge that my treatment program has been explained and that I have been given an opportunity to ask questions. I understand the risks associated with a program of physical, occupational, and/or speech therapy. I confirm that I have read and fully understand this consent form. I wish to proceed with all therapy services.

________________________________ ________________

Name of Patient (Printed) Date

____

Signature of Patient/Legal Guardian

I hereby certify that I have explained the proposed evaluation and treatment. I have offered to answer questions. I believe that the patient/guardian understands what I have explained and answered.

________________________________ ________________

Therapist Signature Date

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Medical Information Release

In order for our staff to discuss your medical care (or your child's medical care) with someone other than yourself (including a spouse or other family member) we must have your consent. If you know of anyone that may be requesting your (or your child's) medical information from our office (not including another physician or clinic) please give your consent below. By signing this you are releasing the staff of Community Sports and Therapy Center from any and all liability for fulfilling this authorization request.

I hereby authorize the staff of Community Sports and Therapy Center to disclose information related to my (or my child's) current episode of care to the person's listed below:

Name ______________________ Relationship ______________________ Telephone ________________

Name ______________________ Relationship ______________________ Telephone ________________

Name ______________________ Relationship ______________________ Telephone ________________

This authorization will expire upon me (or my child) being discharged from this episode of care.

____ ________________

Name of Patient (Printed) Date of Birth

____ ________________

Name of Parent/Legal Guardian, if applicable (Printed) Relationship to Patient

____ ________________

Signature of Patient/Legal Guardian Date

____ ________________

Witness Date

Authorization is valid from the date of signature or until we receive written notification from you. I understand that I may revoke this authorization in writing at any time.

Date Revoked: ______________ **Time:** ________ **Signature:** ______________________________

Patient or Parent/Legal Guardian

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Patient Consent to Photograph, Videotape or Utilize Written Endorsement

1. ________________________________ ____________________

   Full Name Date of Birth

2. I hereby grant Community Sports and Therapy Center permission to photograph/videotape me or to use any written endorsements or communications from me for the following purpose. Check all that apply.

   ☐ Medical Reasons such as diagnosis, care, treatment, research or education throughout my current episode of care.

   ☐ Public Relations Promotion
   This includes granting permission for Community Sports and Therapy Center to use my name in any publicity (i.e. Facebook, Twitter, CSTC website, etc.) accompanying any photograph and/or videotape which has been taken, or written endorsement and communication from me and relinquish any claims of rights to these items and the use of my name with them.

   ☐ Law Enforcement

   ☐ Other (specify): ________________________________

3. I relinquish any claims to any photograph and/or video taken, or written endorsement and communication from me and understand that they are the possession of Community Sports and Therapy Center and/or an appointed agent. I understand that I will receive no compensation for any photograph, videotape, written endorsement and/or communication taken or used.

________________________________ ____________________

Signature of Patient Date

________________________________ ____________________

Signature of Parent/Legal Guardian Date

Relationship to Patient: ________________________

________________________________ ____________________

Witness Date

Minor Child Travel Consent

Patient Name: ______________________________ Date of Birth: ________________ Age: ________

☐ I, ____________________, parent or legal guardian, will organize transportation to and from Community Sports & Therapy Center for ________________________, minor child. I will allow the following names to provide transport for my child.

Name: __________________________________ Relationship to Patient: ______________________

Name: __________________________________ Relationship to Patient: ______________________

Name: __________________________________ Relationship to Patient: ______________________

☐ I, ____________________, parent or legal guardian, give ____________________, minor child, permission to commute to and from Community Sports & Therapy Center without organized transportation.

______________________________________ ______________________

Signature of Parent/Legal Guardian Date

Relationship to Patient: ____________________________

______________________________________ ______________________

Witness Date