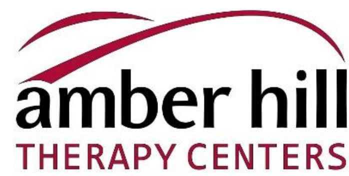

Dear Family,

Welcome to Amber Hill Pediatric Physical and Occupational Therapy services. Thank you for scheduling an initial evaluation with us! The enclosed information is important for you to review before your appointment.

1. Please make sure to read, complete, and sign the enclosed forms prior to your appointment. This information helps us to ensure we are accurately determining your child's insurance benefits and area(s) of need. Every child is unique. Thorough explanations help us in providing the most comprehensive assessment, treatment plan, and goals for your child.
2. Feel free to bring any other information about your child that you believe the therapist may want to look over (e.g. IEPs, letters from teachers/doctors/therapists, evaluations, etc.).
3. The initial evaluation should take about 40 minutes. Parents are welcome to observe the evaluation, so that you can understand the process and help your child feel more at ease.
4. Our staff of highly trained therapists is working hard to help your child. We care about providing quality service to the children with which we work. We understand that people get sick and it's not always possible to give 24-hour cancellation notice. However, we usually have a rather significant waiting list of children who can benefit from our services. Please make sure to carefully read and adhere to our cancellation, scheduling, and no-show policies.

We look forward to meeting with you and your child. If you have any questions or comments, please feel free to contact us at 240-529-0175.

Sincerely,

Kathleen Kober, PT, DPT
KKober@amberhillpt.com
Director of Pediatrics
Amber Hill Physical Therapy

Amber Hill Therapy Centers
Registration Form

Patient Name ______________________________________ Date of Birth _________________________________

Social Security Number _____________________________ Address______________________________________

Phone Number (___) ________________________________ ______________________________________

Referring Physician _________________________________ Doctor's Phone (___) __________________________

Primary Care Physician ______________________________ PCP Phone (___) ______________________________

Email_______________________________________ (You will automatically be enrolled to receive updates, notices and alerts including closures and our monthly newsletter) You may opt out by initialing here______. Once enrolled, you may opt-out at any time.

Have you had prior therapy this year? ☐No ☐Yes If yes, for what condition? ___________________________

Guarantor Information for Medical and Financial Responsibility (Please complete if patient is under 18.)

Guarantor Name_________________________________ Guarantor Phone (____)______________________

Address____

Guarantor's SSN_________________________________

How did you hear about us? Please circle one

Doctor referral **Friend/Family** **Google** **Grocery Carts** **Ad in paper/Magazine**

Website **Internet search** **self-referral** **Event____________** **Other_____________**

Amber Hill Therapy Centers
Important Patient Disclosures

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for *Amber Hill Physical Therapy* to furnish medical care and treatment to _______________________ considered necessary and proper in diagnosing or treating his/her physical condition. (Patient Name)

If patient is under 18 years of age I give Amber Hill Physical Therapy permission to treat _______________ if unattended in the treating area without an adult present. (Patient Name)

Benefit Assignment/Release of Information

I hereby assign all medical benefits to which I am entitled, including private insurance and any other health plans, to *Amber Hill Physical Therapy*. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Scheduling and Cancellation Policy

Amber Hill Physical Therapy reserves the right to bill a minimum $40 no show fee for any appointment not canceled 24 hours in advance. Consistency in treatment is important to your rehabilitation outcome therefore multiple cancellations may result in termination of your treatment or a loss of prime (desired) schedule time.

If you are late for an appointment we may not be able to provide you with treatment as a courtesy to our other patients.

Weather Conditions

Amber Hill Therapy Centers does NOT follow the inclement weather schedule of the surrounding school districts. If we close our office early or your therapist cancels due to weather conditions, you will be contacted by our office. If a decision is made to close the office for the entire day due to inclement weather, it will be announced on our website as well as posted on our Facebook and Instagram page.

Financial Policy Statement

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when the services are rendered. A payment of your estimated share is required to be paid upon each visit. If your insurance carrier does not remit payment within 60 days, the balance will be due in full, from you. If your carrier pays any funds in excess, you will be refunded the credit. All patient balances over 60 days from date of transfer to patient responsibility, will be charged interest monthly at the rate of 10% annually. We reserve the right to discontinue treatment if no attempt to resolve large past due balances is made.

Patient Responsibility

While being treated at Amber Hill Physical Therapy, there may be the need to use certain products to improve your treatment. **As the patient, you are responsible for providing these items at home use. (Exp. Theraband, Electrical Stimulation Pads, Hand therapy products such as Coban, Stretch bandages, TubiGrip, Stockinette or supplies used for Splints)** You may provide these items yourself or you may purchase them from AHPT at a reduced price. These items are not considered durable medical equipment and the cost may not be covered by your insurance company. You are responsible for the cost of any items purchased. AHPT will provide you with a receipt to submit to any Health Care Savings or Flex plans.

Patient Agreement
I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by *Amber Hill Physical Therapy*, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Patient or Responsible Party ___________________________________ Date___/___/___

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____________________________________, have received the Notice of Privacy Practices from Amber Hill Physical Therapy Inc. The notice is dated April 14, 2019.

Signature:_______________________________ Date: _______________

In lieu of patient signature, I, _____________________________________, a staff member of Amber Hill Physical Therapy Inc, state that ____ has been given our current Notice of Privacy Practices.

Signature:______________________________ Date: _______________

Patient History Questionnaire

Patient Name ______________________________________ **Date of Birth** ________________ **Age** ________

Parent's / Guardian's Names: ____

Family Information:

Language(s) spoken in the home: ____

Child lives with: ____

Why are you currently seeking therapy? List Current Concerns / Problem Areas:
____
____
____
____

Please list any injuries, illnesses, infections, hospitalizations, surgeries or other medical procedures your child has had and the ages these occurred:
____
____

Does your child have any allergies? Please specify if allergy is triggered by contact or ingestion.
____
____

Current Medications:
____
____
____

Equipment / Orthotics:
____
____

Developmental Milestones:
At what age did your child do the following?

Roll back to stomach ____________________
Sit unsupported ________________________
Pull to stand ___________________________
Cruise _________________________________
Climb stairs ____________________________
Begin eating solid foods ________________
Use utensils ____________________________

Roll stomach to back _____________
Sit supported ____________________
Crawl ___________________________
Walk ____________________________
Run _____________________________
Finger feed self __________________
Drink from a cup _________________

Amber Hill Therapy Centers— 11793 Fingerboard Road Suite 101 Monrovia, MD 21770
187 Thomas Johnson Drive, Suite 6, Frederick, MD 21702
(P) 240-529-0175 — (F) 301-810-5241
www.amberhillpt.com

Please check all that apply and list any other significant medical history:

__Chronic ear infections	__Hearing deficits
__Tubes	__Seizures
__Tonsils / Adenoid surgery	__Vision deficits
__Reflux	__Torticollis
__Poor sleep	__Frequent antibiotic use
__Colic	__Compromised immune system
__Asthma	__Cardiac issues
__Allergies	__Lyme disease

Please list any additional conditions:

Were there any complications during your pregnancy?
____
____

Were there any complications during your delivery? Type of delivery?
____
____

Did your child experience any problems at birth or soon after?
____
____

As an infant under 6 months, was your child:

Difficult to comfort? ________________________________
____

Passive? ____
____

Consistently active? _________________________________
____

Cuddly, enjoyed being held? __________________________
____

Consistent in sleeping pattern? ________________________
____

Able to hold his/her head up for extended periods of time while being carried? ________________________________
____

Presently would you describe is your child as…

Mostly quiet? ___________________________________

Has difficulty separating from the primary caretaker? ____
____

Overly active? ___________________________________

Falls often? ______________________________________

One who tires easily? ______________________________

Wets the bed? _____________________________________

Impulsive? _______________________________________

Has a poor attention span? __________________________

Resistant to changes? ______________________________

Is frustrated easily? ________________________________

Clumsy, appears awkward? __________________________

Unusual fears? _____________________________________

Have nervous habits or tics? _________________________
____

Has difficulty learning new tasks? (e.g., throwing or catching balls, bike-riding, etc.) ______________________

Can / does your child…

Walk on his/her toes? ______________________________

Jump with both feet? ________________________________

Hop on one foot? _________________________________

Ride a tricycle? ____________________________________

Skip? ____

Ride a two-wheeler without training aides? ____________

Pump self on a swing? _____________________________

Kick a ball? _______________________________________

Does your child hold his / her hands or arms in unusual postures during play? ______________________________
____

Does your child appear loose and “floppy”? Does he/she seem stiff and rigid? _____________________________
____

Does your child have poor sitting and/or standing posture? ____

What kinds of things does your child enjoy or dislike? ____
____

Does your child have any behavior or social concerns? ____
____
____
____

Describe your child's typical day/week (i.e., daycare / school, structured activities, etc.). ____________________
____
____
____

Has your child received PT/ OT in the past or any other kind of therapy? If so, when and where? (Please bring any reports with you to the evaluation.)
____
____
____

Is there anything else you would like us to know about your child? ______________________________________
____
____
____