Allied Rehab
Speech, Occupational & Physical Therapy

900 S. Franklin Street, Suite #201
Wake Forest, NC 27587
(Corner of Hwy 98-Bypass & S. Franklin Street)

Office: 919-556-1700
Fax: 919-556-1245
www.AlliedRehab.net

PEDIATRIC INTAKE FORM (PAGE 1)

Date: _____

Child's Name:

_____
Last Middle First

Date of birth : _____ Current age: _____ years ____ months Male ☐ Female ☐

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

Home #: _____ Cell #: _____ Work #: _____

Email address: _____

How would you prefer we contact you? (home phone, cell phone, email?) _____

Do you give permission to leave health /financial information on voice mail or email? Yes ☐ No ☐

Name of Policy Holder: _____ DOB of policy holder:_____

Insurance Carrier: _____ Policy #: _____

Caregiver's name: _____ Relationship to Child: _____

Siblings: Yes ☐ No ☐ Ages of siblings: _____

Child's school/home schooled/preschool/daycare:_____

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

If so, what services (Speech, occupational, physical therapy, behavioral therapy) where and for how long?

_____

What are your goals for therapy at this time?_____

Please check the following areas of development where you have concerns:

Speech: Yes ☐ No ☐

Gross motor (rolling, crawling, walking): Yes ☐ No ☐

Fine motor (coloring, writing, cutting): Yes ☐ No ☐

Primary Care Practice Name: _____

Physician: _____ Physician Phone Number: _____

Medical History

Birth Weight: _____ Full Term ☐ or Premature ☐ If so, how many weeks early?_____

Delivery: Vaginal ☐ C-section ☐

Presentation: Sunny side up ☐ Breech ☐ Normal ☐

Allied Rehab
Speech, Occupational & Physical Therapy

900 S. Franklin Street, Suite #201
Wake Forest, NC 27587
(Corner of Hwy 98-Bypass & S. Franklin Street)

Office: 919-556-1700
Fax: 919-556-1245
www.AlliedRehab.net

PEDIATRIC INTAKE FORM (PAGE 2)

Child's Name _____ Current Age _____

Any birth complications? Yes ☐ No ☐
Required Oxygen? Yes ☐ No ☐ Intubated? Yes ☐ No ☐
NICU stay? Yes ☐ No ☐ If so, how long? _____
Other birth complications? _____
Has any illness, injury or accident occurred that may have impacted your child's development?
If so, please explain and say when:

_____

Date of last hearing screening: _____ Results: _____

Does your child have frequent ear infections: Yes ☐ No ☐ If yes , how often? _____

Does your child have ear tubes? Yes ☐ No ☐ If yes, when were they placed? _____

Does your child have any of the following medical diagnoses?

Abdominal/Stomach Issues ____	Cerebral Palsy ____	Hearing Loss ____
ADD ____	Congenital Heart Disease ____	High Blood Pressure ____
ADHD ____	Diabetes ____	Muscular/Skeletal Conditions ____
Asthma ____	Type _____	Reflux ____
Aspergers ____	Digestive Issues ____	Seizures ____
Autism ____	Down Syndrome ____	Sleep Disorders ____
Behavioral/Emotional Disorders ____	Excessive Fatigue ____	Vision Problems/Glasses ____
Breathing Problems ____	Head Injury/Concussion ____	

Please list details AND any other medical conditions not mentioned above:

_____

_____

Does your child have any allergies? Yes ☐ No ☐ If so, please list:

_____

Has your child been been hospitalized? Yes ☐ No ☐
Has your child had any surgeries or procedures? Yes ☐ No ☐ If Yes , please explain:
Date:_____ Reason:_____
Date: _____ Reason: _____

Current medications: _____

_____

Allied Rehab
Speech, Occupational & Physical Therapy

900 S. Franklin Street, Suite #201
Wake Forest, NC 27587
(Corner of Hwy 98-Bypass & S. Franklin Street)

Office: 919-556-1700
Fax: 919-556-1245
www.AlliedRehab.net

POLICIES OF ALLIED REHAB (PAGE 3)

Treatment Consent
I consent to therapy considered necessary in diagnosing and/or treating my condition.

Authorization and Release
I authorize Allied Rehab to bill and receive payments from my insurance company. I also permit the release of necessary information, including medical records, to my insurance company.

Financial Policy
Payment of all co-pays, deductibles and any portion not covered by my insurance company is due at time of service. ALLIED REHAB WILL BILL MY INSURANCE CARRIER AS A COURTESY TO ME. Allied Rehab CANNOT guarantee insurance benefits given by the insurance company to be 100% accurate. The information Allied Rehab receives IS NOT A GUARANTEE of payment from the insurance company. It is recommended that I call and verify benefits prior to my scheduled appointment. I understand that I am responsible for any portion not covered by my insurance company and prompt payment is required. An 8% interest fee will incur on any balance greater than 30 days. Accounts sent to collections will incur additional fees

No-Show Policy
It is important that I keep all scheduled appointments to obtain maximum benefit from my rehabilitation program. Being on time for these appointments is IMPERATIVE! The therapist has blocked this time especially for me. Not showing or giving less than 24 hrs notice to cancel, takes time away from other patients who would have benefited from this appointment. A $50 fee will be charged to my account for a no-show or late cancellation.

PLEASE INITIAL THAT YOU HAVE READ OUR POLICY OF A $50.00 NO SHOW FEE _____

I have read, understood and accepted the above policies as indicated by my signature below.

Name: _____

Signature: _____

Witness: _____ Date: ____/____/____

Allied Rehab
Speech, Occupational & Physical Therapy

900 S. Franklin Street, Suite #201
Wake Forest, NC 27587
(Corner of Hwy 98-Bypass & S. Franklin Street)

Office: 919-556-1700
Fax: 919-556-1245
www.AlliedRehab.net

PATIENT HEALTH & SAFETY POLICY FOR MINORS (PAGE 4)

It is the intent of Allied Rehab to provide excellent rehab therapy services to all patients in a safe and secure environment. Therefore, it is imperative that the parent/guardian or designated adult accompanying a minor child to Allied Rehab must stay in the premises of Allied Rehab during the therapy session.

Child's Name: _____ Date of Birth: ____/____/____

Parent/Guardian Signature: _____

Parent/Guardian (Print Name): _____

Allied Rehab
Speech, Occupational & Physical Therapy

900 S. Franklin Street, Suite #201
Wake Forest, NC 27587
(Corner of Hwy 98-Bypass & S. Franklin Street)

Office: 919-556-1700
Fax: 919-556-1245
www.AlliedRehab.net

PHOTO RELEASE AGREEMENT (PAGE 5)

I hereby authorize Allied Rehab Inc., to take photographs of me/my child to be used for general marketing materials.

No identifying information (i.e., name, address, or illness) will accompany the images.

I hereby release and hold harmless Allied Rehab Inc. from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release Allied Rehab Inc., its employees, Physical, Speech and Occupational Therapists involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

☐ I **do not** authorize Allied Rehab to take photographs of me/my child.

Signature: _____

Authorization

Parent/Guardian Signature: _____

Parent/Guardian (Print Name): _____Date: ____/____/____

What is the relationship to the minor child?_____

Witness Name (Print):_____ Signature:_____