KIDS CARE PATIENT REGISTRATION FORM

PATIENT INFORMATION			
PATIENT'S NAME:	DATE OF BIRTH:	GENDER (CIRCLE): M F	
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	WORK PHONE: EXT:	CELL PHONE:	
SOCIAL SECURITY #:	EMAIL ADDRESS:		
EMPLOYER:	OCCUPATION:	EMPLOYER PHONE:	
EMERGENCY CONTACT:	RELATION:	CONTACT PHONE:	

Thomas Nicolla Consulting Services will NOT share your information with any other company or third party. By providing your email address, you consent to receiving email communication and patient statements. By providing phone numbers above, I am granting permission to contact me at any of those noted.

PHYSICIAN INFORMATION	
REFERRING PHYSICIAN:	DIAGNOSIS:
IS YOUR INJURY? (CHECK ONE) ☐ WORK RELATED ☐ AUTO RELATED ☐ MOTORCYCLE ☐ OTHER?	
DO YOU HAVE A FOLLOW UP SCHEDULED WITH YOUR DOCTOR? (CIRCLE): YES NO	
ARE YOU CURRENTLY SEEING A CHIROPRACTOR FOR THIS INJURY? (CIRCLE): YES NO	
ARE YOU CURRENTLY BEING SEEN AT HOME FOR ANY HEALTH CARE SERVICES? (CIRCLE): YES NO	
HAVE YOU SEEN A PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST, SPEECH THERAPIST OR CHIROPRACTOR IN THE PAST YEAR? (CIRCLE): YES NO	

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)		
INSURANCE COMPANY:		
NAME OF INSURED:	MEMBER #:	GROUP #:
SUBSCRIBER'S SOCIAL SECURITY #:	DATE OF BIRTH:	RELATION:
SECONDARY INSURANCE (IF APPLICABLE):		
NAME OF INSURED:	MEMBER #:	GROUP #:
SUBSCRIBER'S SOCIAL SECURITY #:	DATE OF BIRTH:	RELATION:

PARENT / GUARDIAN
☆ SINCE THEPATIENT IS UNDER 18 AND CONSIDERED A MINOR, WE REQUIRE THE FOLLOWING INFORMATION FROM THE PATIENT'S PARENT OR GUARDIAN
PARENT / GUARDIAN NAME:
PARENT / GUARDIAN DATE OF BIRTH:
PARENT / GUARDIAN SOCIAL SECURITY #:

AUTOMOBILE ACCIDENT	
IS THIS A NO FAULT CASE (AUTOMOBILE ACCIDENT)? (CIRCLE): YES NO	DATE OF INJURY:
IF YES, NO-FAULT INSURANCE COMPANY:	
INSURANCE COMPANY ADDRESS:	
CASE MANAGER NAME:	PHONE NO:
CLAIM #:	POLICY #:

AKNOWLEDGEMENT

I acknowledge that the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the practice. I understand that I am financially responsible all charges not paid by said insurance, including any co-payments (which I agree to pay prior to service provided), deductibles, coinsurance as well as any charge for no show and cancellation of appointments. In the event of default or if the account is referred to an attorney or collection, the undersigned agrees to pay for any collection or attorney's fees incurred as a result of delinquency.

Patient/Guardian signature Date

THOMAS NICOLLA CONSULTING SERVICES, PLLC

711 Troy-Schenectady Road, Suite 209
Latham, New York 12110
Tel: 518-786-1667 Fax: 518-786-1954

FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing you with the best possible care. If you have insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of your payment policy.

We participate with:

* Aetna
* APA Partners Health
* Blue Shield of NENY
* CDPHP
* Empire BC/BS, Blue Choice, Healthnet
* Empire Plan/United Healthcare
* Fidelis
* GHI/GHI HMO
* MVP
* No Fault
* Tri-Care
* Wellcare

Through these arrangements, we will bill on behalf of the patient and the patient will be responsible for any co-pays, deductibles or non-approved charges. **COPAYS and/or DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.**

COMMERCIAL INSURANCE:

1. We will submit the initial claim directly to your carrier. In the interim, a statement will be sent monthly to the responsible party – **THE PATIENT**!
2. Your insurance is a contract between you, your employer, and the insurance company. We encourage you to follow up with your carrier to ensure timely payments.
3. Payments for services rendered are due 30 days following the date of service, regardless of insurance.

I understand and agree I am ultimately responsible for the balance on my account.

NO FAULT:

Patient MUST provide us with an accurate Name and Address of the Insurance Company and the Date of the Accident.

NO FAULT: Name/Address of Insured, Policy Number and Claim/File Number.

ADDITIONAL CHARGES:

As a courtesy to other guests and team members, please give us a **24 hour notice of cancellation**. Failure to do so will result in a $25.00 fee.

There will also be a $25.00 service charge for all returned checks. Our billing office is here to assist you. With your help, we hope to make the payment of this claim a positive experience. Please direct your questions to our billing office at 786-1667. Thank you for your cooperation!

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I realize that I am responsible for all collection costs and/or attorney costs incurred by Thomas Nicolla Consulting Services, PLLC in an effort to collect my bill. Balances not paid within 30 days are subject to a finance charge.

I acknowledge that Kids Care instructed me on how to contact my insurance company to determine the PT or OT benefits for my child.

I acknowledge it is my responsibility to pay all co-pays and/or deductibles at the time of the therapy visit.

PATIENT NAME:_____

PARENT/GUARDIAN NAME:_____RELATIONSHIP TO PATIENT:_____

SIGNATURE:_____ DATE: _____

KIDS CARE Pediatric Rehabilitation Services

PEDIATRIC PATIENT HISTORY FORM

Patient Name:_____ Date:_____

****PLEASE CHECK ALL ANSWERS AND FILL IN ALL BLANKS WHERE APPROPRIATE****

Date of Birth:_____

Referring Diagnosis:_____

Referring Physician:_____

Parent/Guardian Names:_____

PRENATAL HISTORY

1. Were you taking any medications during your pregnancy? □ Yes □ No
   If yes, please list medications and reasons:_____
2. Did you use any of the following during your pregnancy?
   Tobacco/Cigarettes □ Yes □ No How often?_____
   Alcohol □ Yes □ No How often?_____
3. Please check any complications during pregnancy:
   □ Excessive Vomiting □ Measles □ Bleeding □ Swelling
   □ High Blood Pressure □ Toxemia □ Diabetes □ Weight Loss
   □ Other *(please specify):*_____

BIRTH HISTORY

1. Delivery *(please check any complications)*
   □ Excessive Blood Loss □Twisted Cord □ Breech Birth
   □ Ruptured Membranes (more than 24 hrs)
   □ Other *(please specify):*_____
2. Was your child born □ Early □ Late □ On-Time
3. Length of pregnancy: Gestational Age_____weeks
4. Delivery: □ Vaginal □ Cesarean Section
5. Birth Weight: _____ Apgar Score (if known) ___/10 1min, ___/10 5 min
6. How long was your child hospitalized following delivery?_____
   Discharge Date:_____
7. Did your child experience complications or receive special attention?
   □ Yes □ No If yes, please describe:_____
8. Was your child □ Nursed □ Bottle Fed

CHILD'S HISTORY

1. Has your child ever been hospitalized or undergone surgery? □ Yes □ No
   If yes, please explain the reason and length:_____
   _____
2. Does your child have allergies? □ Yes □ No
   If yes, please describe:_____

3. Please check any of the following that apply to your child:

Heart Condition	□ Yes □ No
Seizure Disorder	□ Yes □ No
Asthma	□ Yes □ No
Frequent Ear Infections	□ Yes □ No
Diabetes	□ Yes □ No
Hearing Impairments	□ Yes □ No
Visual Impairments	□ Yes □ No
Difficulty in Swallowing/Eating	□ Yes □ No
Dermatitis/Eczema Rash	□ Yes □ No
Congenital Deformities	□ Yes □ No
Irregular Sleep Habits	□ Yes □ No
Persistent Irritability	□ Yes □ No
Withdrawn or Isolated Behavior	□ Yes □ No
Markedly Limited Attention Span	□ Yes □ No
Other:_____	

5. Is your child on prescribed medication? □ Yes □ No If yes, please list medications and explain:

_____

_____

6. Please list all physicians involved in your child's care and specify for what medical condition:

_____

_____

7. Please list approximate ages in which your child accomplished the following milestones:

Rolled from the stomach to back	_____months
Reached for objects	_____months
Rolled from back to stomach	_____months
Crawled on stomach	_____months
Crawled on hands and knees	_____months
Sat independently	_____months

8. When did you begin having concerns regarding your child's development?

_____

9. Please list your current concerns regarding your child's development:

_____

_____

_____

10. Has your child ever received □ Occupational Therapy □ Physical Therapy
Please explain prior treatment/response (school based/outpatient, etc.):

_____

_____

_____

11. What would you like to accomplish with therapy?

_____

_____

_____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/INFORMATION

I, _____ authorize Thomas Nicolla Consulting Services, PLLC to release my medical records and/or medical information to:

_____ _____
(name) (relationship to the patient)

For the purpose of:

□ Making appointments □ Handling medical information □ Other: _____

FOR PATIENTS WHO ARE UNDER 18 YEARS OLD (MINORS)

Please list below the name(s) and phone number(s) of the patient's legal guardian(s).

1. _____ _____
(name) (phone number)
2. _____ _____
(name) (phone number)

_____
Patient's Signature Date

_____
Witness Signature Date

*****PLEASE NOTE: If someone other than you (the patient) will be handling your billing information, appointment scheduling, changing appointments, etc., you must sign this form in order for us to comply with your request. Thank you for your cooperation.**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Thomas Nicolla Consulting Services, PLLC is committed to keeping your health information confidential. We utilize this information for practices involving treatment and billing of your sessions, and in any necessary support of day to day activities and management.

Under federal privacy standards, (HIPAA), you have certain individual rights including the right: to request restrictions on the use and disclosure of your protected health information, to receive confidential communications concerning your medical condition and treatment, to inspect and copy your protected health information, to amend or submit corrections to your protected health information, and to receive an accounting of how and to whom your protected health information has been disclosed. All requests must be submitted in writing.

I have read the above abbreviated version of the Privacy Practices for Thomas Nicolla Consulting Services, PLLC and understand that I may request a copy of the full version at any time.

_____
Patient's Signature Date

_____
Witness Signature Date