368 Quarry Loop Road
Mt. Juliet, TN 37122
615-443-4445 phone 615-443-4448 fax
Admin@DynamicTherapyCenter.com

ANNUALLY UPDATED REGISTRATION PACKET

THIS INFORMATION WILL BE KEPT CONFIDENTIAL

PATIENT INFORMATION: PLEASE PRINT

Child's Name: (First)_____(Middle)_____(Last)_____
What name does he/she like to be called:_____
Address:_____
City:_____State:_____Zip Code:_____
Home Phone: (_____)_____-_____Gender: M/F Date of Birth:_____/_____/_____ Race:_____
Best phone number to reach a parent or guardian: (_____)_____-_____ Best time to call?_____
Social Security Number of Child: _____-_____-_____
Primary Care Physician: _____ Phone: (_____)_____-_____
Address:_____
City:_____State:_____Zip Code:_____
Referring Physician: _____ Phone: (_____)_____-_____
Address:_____
City:_____State:_____Zip Code:_____

RESPONSIBLE PARTY: PLEASE PRINT

1ST Parent or Guardian Information: Relationship to Child: _____
Name: (First)_____(Middle)_____(Last)_____
Address: _____
City:_____State:_____Zip Code:_____
Home #: (_____)_____-_____ Cell #: (_____)_____-_____ E-mail:_____
Place of Employment:_____Work Phone: (_____)_____-_____

2nd Parent or Guardian Information: Relationship to Child:_____
Name: (First)_____(Middle)_____(Last)_____
Address: _____
City:_____State:_____Zip Code:_____
Home #: (_____)_____-_____ Cell #: (_____)_____-_____ E-mail:_____
Place of Employment:_____Work Phone: (_____)_____-_____

Signature:_____Date:_____

INSURANCE INFORMATION: (PLEASE PRINT)
Is the child the insurance subscriber? Y/N

PRIMARY INSURANCE: SUBSCRIBER'S INFORMATION
Name: (First)_____(Middle)_____(Last)_____
Social Security #: _____-_____-_____ Gender: M/F Date of Birth: _____/_____/_____
INSURANCE COMPANY:_____
Effective Date:_____/_____/_____ Ending Date:_____/_____/_____
Member ID#: _____
Group Name:_____ Group #:_____
Co-Pay $:_____ Deductible $:_____
Is Authorization required for service? Y/N
(OFFICE USE ONLY): Insurance verified date:_____/_____/_____ Active: Y/N

SECONDARY INSURANCE: SUBSCRIBER'S INFORMATION
Name: (First)_____(Middle)_____(Last)_____
Social Security #: _____-_____-_____ Gender: M/F Date of Birth: _____/_____/_____
INSURANCE COMPANY:_____
Effective Date:_____/_____/_____ Ending Date:_____/_____/_____
Member ID#: _____
Group Name:_____ Group #:_____
Co-Pay $:_____ Deductible $:_____
Is Authorization required for service? Y/N
(OFFICE USE ONLY): Insurance verified date:_____/_____/_____ Active: Y/N

CONSENT FOR SERVICES

Patient's Name:_____ DOB: _____/_____/_____
Parent/Caregiver Name:_____ Relationship to Patient:_____
I, _____(parent/caregiver), hereby give my consent for Dynamic Therapy Center and/or personnel to provide the services listed below at the location listed below:
Evaluation_____ Treatment_____
To be performed at Dynamic Therapy Center, 368 Quarry Loop Road, Mt. Juliet, TN 37122.

Signature:_____Date:_____

FINANCIAL AGREEMENT/AUTHORIZATION FOR BILLING AND PAYMENT OF SERVICE

I authorize Dynamic Therapy Center to contact Medicaid and/or my private insurance company to confirm benefits and release information necessary to process claims. I authorize payment(s) directly to Dynamic Therapy Center for services rendered. I understand that I am responsible for any co-pay/co-insurance and/or deductible amounts associated with the patient's benefits. I understand that is my responsibility to know my benefits and that verification of benefits by Dynamic Therapy Center is not a guarantee of payment. I understand if insurance is denied, I am responsible for payment of services rendered.

Signature:_____Date:_____

HIPAA RELEASE OF INFORMATION AND AUTHORIZATION

I consent for Dynamic Therapy Center, to use the patient's Medical Information for the purpose of providing treatment, payment of services and for Dynamic Therapy Center general healthcare operations purposes. Medical information means for any information, including demographic information, created or received by Dynamic Therapy Center that is related to past, present, or future health conditions; information that relates to the provision of health care; information that relates to past, present, or future payment for the provision of health care services; and information that can be used to identify the patient. I have received the Notice of Privacy and Practices and understand the conditions under which information will be used and disclosed. I understand I have the right to revoke this authorization by providing written notice to Dynamic Therapy Center. However, this authorization may not be revoked if Dynamic Therapy Center has taken action on its authorization prior to receiving my written notice. This authorization is valid from the date of my signature below and will expire on the date my coverage ends with Dynamic Therapy Center.

Signature:_____Date:_____

AUTHORIZATION FOR SUPERVISION DURING A SESSION

The following person(s) may be present in the absence of the parent/guardian during a therapy session: _____

**At my request, the following person(s) may NOT be present during a therapy session:_____

_____

Signature:_____Date:_____

AUTHORIZATION FOR PHOTOGRAPHS AND VISUAL MEDIA

I grant Dynamic Therapy Center, it's representatives/employees the right to take photographs/videos of my child,_____(child's name). I authorize Dynamic Therapy Center, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that Dynamic Therapy Center may use such photographs/videos of me/my child with or without my name for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content. I have read, understand, and agree to the above written statement.

Signature:_____Date:_____

PATIENT ATTENDANCE POLICY

It is the policy of Dynamic Therapy Center to provide excellent therapeutic services to all of our patients; therefore it is important that all of our patients keep their scheduled appointments as recommended by the evaluating therapist. We try to accommodate all of our patients, but missed appointments prevent us from being able to help your child reach his or her maximum potential. We realize there may be situations where your child may need to miss a session, such as medical appointments or illnesses. Other issues, such as weather or transportation are not appropriate reasons for cancelling a treatment session that has been previously scheduled. We are assuming because this appointment will be a standing appointment, you will have secured the necessary transportation ahead of time. This policy is necessary to ensure that your child and others are fully benefiting from therapies, and treatment times are not wasted by repeated absences while other children remain on the waiting list. At any given time, we have over 100 other treatment sessions waiting to be scheduled by families wanting services for their child.

Therefore, Dynamic Therapy Center requires the following:

Approved Cancellation – An *Approved Cancellation* will be granted when due to family emergencies such as hospitalizations or funerals, or patient documented illnesses such as vomiting, diarrhea, fever >100 degrees, unexplained rashes, or other contagious medical conditions. Please call the office (615-443-4445) as soon as possible to notify us that your child is too ill to attend. A physician's note may be requested with repeated cancellations for reason of illness.

Approved Advanced Cancellation – *Approved Advanced Cancellations* may be approved due to medical appointments or family situations if requested in advance. In order for a cancellation to be approved for a non-illness related reason, it must be requested in writing 7 days prior to your scheduled appointment.

Unapproved Cancellation – *Unapproved Cancellations* are considered "Unapproved" if for any reason other than illness or a planned advanced cancellation with less than 7 days written notice. Because of the significant waiting list, a child will forfeit their treatment time and be placed on the waiting list for another available time if a child has the following:

*Two Unapproved Cancellations in a row

*Two Unapproved Cancellations in a four week time period

In addition to our attendance policy, Dynamic Therapy Center has a strict **NO SHOW Policy**. A *NO SHOW* is a missed therapy visit with no call to cancel prior to the scheduled appointment time. If a child fails to show for a scheduled appointment and the family does not call to cancel, it is considered a *"NO SHOW"*. A child will be discharged from therapy after two *NO SHOW's* and the pediatrician will be notified. In order to get back on the therapy schedule, the parent/guardian must contact the pediatrician for another therapy referral order. Patient demands require that we reduce our number of *NO SHOW'S* in order to continue to strive to give you the best possible services for your child and be fair to those who are on the waiting list.

If you call to cancel and cannot get through, please call back in the evening and leave a message. Our voicemail is checked every morning.

I have read, understand, and agree to the above written Patient Attendance Policy, and additional information and details regarding illnesses and tardiness as described in the Patient Handbook that I have also received.

Signature:_____Date:_____

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MEDICAL RELEASE FORM

PATIENT INFORMATION: PLEASE PRINT
Child's Name: (First)_____(Middle)_____(Last)_____
Address:_____
City:_____State:_____Zip Code:_____
Best Phone: (_____)_____-_____Gender: M/F Date of Birth:_____/_____/_____ Race:_____

I, _____(legal guardian), authorize Dynamic Therapy Center to release or request any medical information which is necessary in providing therapy services for my child to/from the following agencies:

Pediatrician:_____

Case Manager:_____

Other Agencies/Therapists:_____

Hospitals/Clinics/Health Departments:_____

School Systems:_____

Other:_____

I acknowledge receipt of information between Dynamic Therapy Center and the above named facilities/agencies. I acknowledge receipt of the Notice of Privacy Practice and understand the conditions under which information will be used and disclosed. I understand the types of information that may be disclosed to the above named persons. I understand that I can add to or remove the authorization of any person(s) at any given time by providing a written request to Dynamic Therapy Center. This authorization will be in effect for one year after the date of signing.

Parent/Guardian Signature:_____Date:_____

PARENT COMMENTS

My child has been receiving the following services at Dynamic Therapy Center:_____
_____
_____
_____

I have noticed improvements in the following areas: _____
_____
_____
_____

Continued concerns as a parent about my child include: _____
_____
_____
_____

Please describe any significant life changes over the past year for your child/family (death of family member(s), addition of family member(s), lost jobs, moving to new environment, changing schools, etc.): _____
_____
_____
_____

Please list current medications: _____
_____

Please list allergies:_____

PHYSICIAN INFO			
Name	**Specialty**	**Reason**	**Date of last visit**

Diagnostic Tests		
Test	**When**	**Details/Results**
Auditory Brainstem Response		
Biopsy		
Blood Work / Lab Tests		
Bone Density Scan		
CT Scan		
EEG		
EMG		
Lower GI		
Motility Study / Empty Scan		
MRI		
NCV		
Swallow Study		
Ultrasound		
Upper Endoscopy		
X-Ray		

Please describe any new medical procedures/diagnoses for your child over the past year (ie., braces, illnesses, surgeries, tongue clipped, seizures, flu, tubes in ears, etc.

Surgeries/Procedures		
Type	**Date**	**Results/Details**

Equipment presently used (Please select all that apply):

Equipment	Approx. Age	Details	Uses at Home	Uses at School/Day Care
Braces				
Walker				
Stander				
Manual Wheelchair				
Power Wheelchair				
Hoyer Lift				
Weighted Vest				
Hand Splint(s)				
Track System				
Other:				

Grade in School:_____ Name of School:_____
School District:_____

Does your child have an IFSP? ____YES ____NO
Does your child have an IEP? ____YES ____NO
Has your child had a psychological or neuropsychological evaluation completed? _____YES _____NO
(Please bring in and ask the front office to make a copy of any evaluations that were completed by another agency/school system this past year for your child's file at Dynamic Therapy Center. Thank you!)

Therapy Services	Type	Status	How often?	Where?
Assistive Technology				
Audiology				
Behavior Therapy				
Developmental History				
EI Services				
Intensive Suit Therapy				
Vision Therapy				
Nutrition				
Occupational Therapy				
Physical Therapy				
Social Therapy				
Speech / Language Therapy				
Developmental Follow-up Clinic				
Other:				

Any other information you feel we should know: _____
_____
_____
_____
_____
_____
_____
_____
_____

Signature:_____Date:_____