



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

NEW PATIENT 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 CONCERNS

My concerns as a parent about my child include: _____

OTHER MEDICAL HISTORY/CONDITIONS/BEHAVIOR

Child's general health is: _____ Good _____ Fair _____ Poor

Provide the "approximate" age(s) at which the child experienced the following illnesses or conditions:

_____ Headaches	_____ Asthma	
_____ Chicken Pox	_____ Colds	_____ Convulsions
_____ Croup	_____ Dizziness	_____ Epilepsy
_____ Ear Infections	_____ Drainage of the ears	_____ Hearing Loss
_____ Heart Problems	_____ High Fevers	_____ Encephalitis
_____ Influenza (the "Flu")	_____ Measles	_____ Pneumonia
_____ Adenoidectomy (removal of adenoids)	_____ German Measles	_____ Mastoiditis
_____ Other: _____		

How does your child interact with other family members? _____

Is your child: _____ Attentive _____ Extremely Active _____ Restless

Does your child bang his/her head? _____ yes _____ no

Does your child rock or spin? _____ yes _____ no

Does your child play by his/herself? _____ yes _____ no

Does your child lose his/her temper? _____ yes _____ no

How does your child interact with other children? _____

With whom does your child spend most of the day with? _____ (relationship) _____

Signature: _____ Date: _____

Medical History

Patient Name: _____

Pregnancy/Delivery

Pregnancy Proceeded ☐ Without Complications
☐ With Complications
 ☐ Eclampsia ☐ Positive for Strep
 ☐ Gestational ☐ B Pre-eclampsia
 ☐ Diabetes Multiple ☐ Premature Labor
 ☐ Births ☐ Substance
 ☐ Polyhydramnios ☐ Exposure Toxemia
 ☐ Positive for Cytomegalovirus ☐ Other _____
 ☐ 'CMV' Positive for Herpes
 ☐ Positive for HIV

Length of Pregnancy (in weeks) _____ Prenatal care was ☐ Received ☐ Not Received

Delivery Proceeded ☐ Without Complications
☐ With Complications
 ☐ Abruptio Placenta ☐ Premature Rupture of Membranes
 ☐ Breech Position ☐ Transverse Position/Prolapsed Cord
 ☐ Low Birth Weight ☐ Use of Forceps
 ☐ Negative Vacuum ☐ Uterine Rupture
 ☐ Non-progressive/unproductive Labor ☐ Umbilical Cord Wrapped Around Neck
 ☐ Occiput Posterior Position ☐ Other _____
 (Face up) Placenta Previa

Delivery was ☐ Vaginal ☐ C-section ☐ Emergency C-section Length of child's hospital stay: _____

Mother's age at time of birth _____ Birth Hospital _____

Needed to be transferred to another hospital Yes No

Transfer Hospital _____

Birth Weight _____ Birth Height _____ Apgar 1 min _____ 5 min _____ 10 min _____

Additional Comments _____

Multiple child pregnancies: # of live births: _____ # of still births: _____

Additional details of birth _____

Complications Following Birth

- | | |
|---|---|
| <input type="checkbox"/> Anemia of Prematurity | <input type="checkbox"/> Jaundice treated by light therapy &/or blanket |
| <input type="checkbox"/> Bronchopulmonary Dysplasia 'BPD' | <input type="checkbox"/> Meconium Aspiration |
| <input type="checkbox"/> Cleft Lip | <input type="checkbox"/> Necrotizing Enterocolitis 'NEC' |
| <input type="checkbox"/> Cleft Palate | <input type="checkbox"/> Neonatal hypoxia |
| <input type="checkbox"/> Club Foot | <input type="checkbox"/> Oxygen dependency |
| <input type="checkbox"/> PDA | <input type="checkbox"/> Cytomegalovirus ECMO |
| <input type="checkbox"/> Failure to Thrive | <input type="checkbox"/> Positive Dependency |
| <input type="checkbox"/> Hyperbilirubinemia | <input type="checkbox"/> Respiratory Distress Syndrome |
| <input type="checkbox"/> Intrauterine Growth Retardation | <input type="checkbox"/> Respiratory Stridor |
| <input type="checkbox"/> 'IUGR' IVH Bleed Grade I | <input type="checkbox"/> Respiratory Syncytial Virus 'RSV' |
| <input type="checkbox"/> IVH Bleed Grade II | <input type="checkbox"/> Retinopathy of Prematurity 'ROP' |
| <input type="checkbox"/> IVH Bleed Grade III | <input type="checkbox"/> Thrombocytopenia (Low Platelet) |
| <input type="checkbox"/> IVH Bleed Grade IV | <input type="checkbox"/> Ventilator Dependency |
| | <input type="checkbox"/> VP Shunt |
| | <input type="checkbox"/> Other |

Diagnosed or Suspected Syndromes: _____

Current Medications: _____

Allergies: _____

Current Vitamins, Herbs, Minerals, Homeopathics: _____

Hearing Test: please circle

Never Tested, No Concerns

Never Tested, Have Concerns

Normal Test Results

Abnormal Test Results

Last Test Date _____

Results

Concerns

Vision Test

Never Tested, No Concerns

Never Tested, Have Concerns

Normal Test Results

Abnormal Test Results

Last Test Date _____

Results

Concerns

Current Physicians

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		

Surgeries and Procedures		
Type	Date	Results/Details

Does the child have:

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Colic | <input type="checkbox"/> Scoliosis Degrees? _____ |
| <input type="checkbox"/> Arteriovenous malformation (AVM) | <input type="checkbox"/> Constipation | <input type="checkbox"/> Seizure Condition |
| <input type="checkbox"/> Anoxic brain injury | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Asthma/respiratory breathing problems | <input type="checkbox"/> Down | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Syndrome Hip | <input type="checkbox"/> Shunts |
| <input type="checkbox"/> Baclofen Pump | <input type="checkbox"/> Subluxation | <input type="checkbox"/> Torticollis |
| <input type="checkbox"/> Cerebral Palsy (CP) | <input type="checkbox"/> Hydrocele | <input type="checkbox"/> Traumatic brain injury (TBI) |
| <input type="checkbox"/> Cerebral Vascular Accident (CVA) | <input type="checkbox"/> Laryngomalacia | <input type="checkbox"/> Tube Feeding |
| <input type="checkbox"/> Chronic Ear Infections | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Tubes in ears |
| | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Vagal Nerve Stimulator |
| | <input type="checkbox"/> Periventricular | <input type="checkbox"/> None |
| | <input type="checkbox"/> Lukomalasia Reflux | |

Other Medical Conditions:

Orthopedic Conditions:

Additional Comments:

Developmental History

Is the child able to:	Began at age (in months):
Bringing both hands to mouth	
Buttoning pants/shirt	
Come to sitting from a lying position	
Creeping or crawling alone	
Fully Toilet trained	
Grabbing a toy	
Holding head up alone	
Pulling self to standing position	
Rolling Over	
Self-bathing	
Self-dressing	
Sitting alone without support	
Standing unsupported	
Tying shoes	
Walking with support	
Walking unaided	
Zippering/unzipping jacket	

Is your child ___Right Handed ___Left Handed ___Not yet determined

Concerns about handwriting? ___Yes ___No Describe: _____

How does child get around the house? _____

Favorite Toys / Play Activities _____

Description of Child (please select all that apply)

___Active ___Cautious ___Distractible ___Insecure ___Playful ___Other: _____
 ___Affectionate ___Curious ___Fearful ___Motivated ___Shy
 ___Aggressive ___Demanding ___Fearless ___Passive ___Stubborn
 ___Calm ___Difficult to Comfort ___Fussy ___Persistent ___Withdrawn

Sensory processing & Regulation (please select all that apply)

___Avoids getting messy ___Resists certain movements (e.g. bouncing, swinging, upside down)
 ___Seeks out (craves) touch or movement ___Has difficulty figuring out how to move body or takes more time with movements
 ___Stumbles or falls frequently ___Does not tolerate certain textures (e.g. clothing, surfaces, foods)
 ___Appears awkward or less coordinated ___Uses lots of pressure when touching someone or holding object
 ___Flaps hands ___Has difficulty transitioning from one activity to another
 ___Allows brushing of teeth ___Has difficulty falling asleep
 ___Bangs on surface, bangs/hits head ___Has difficulty remaining asleep through the night
 ___Fatigues quickly ___Appears lethargic/sleepy all the time
 ___Has self-abusive behaviors ___Has poor sense of body in space, runs into things
 ___Resists certain tasks or environment ___Seeks support for posture (e.g. leans on furniture, walls or people, holds head)
 ___Spins things or self ___Demonstrates stiff or rigid movement patterns
 ___Is sensitive to lights, sounds or noise ___Hyperfocussed (on specific tasks, people, objects, etc.)
 ___Sleeps a lot ___Other: please describe _____
 ___Resists touch
 ___Walks on toes
 ___Lines up toys or objects
 ___Seeks out (craves) visually stimulating objects
 ___Seeks out (craves) stimulating sounds

Social/Emotional Skills☐ Is easily distracted☐ Prone to emotional outbursts☐ Only plays with adults☐ Calms self easily☐ Doesn't allow others to join in play☐ Prefers to play alone☐ Gets angry/frustrated easily☐ Has difficulty making friends☐ Has difficulty with separations☐ Is aggressive towards others☐ Plays with peers☐ Has poor eye contact☐ Other: please describe _____**Feeding**

Describe Any Feeding Problems

Food Likes

Food Dislikes

Feeding Milestones

When did the child begin?	Age (in months)	Milestone	Age (in months)
Using a Bottle		Using a Straw	
Using a Pacifier		Stop Using a Bottle	
Eating baby food		Stop Using a Pacifier	
Eating junior food		Using Utensils to Eat	
Eating table food		Holding own bottle/cup	
Drinking from a Cup		Self-feeding	
Drinking from a Sippy Cup			

Breast Feeding

times currently breast fed per day _____

Weaned from breast feeding at age: _____

Was never breast fed: _____

Current Feeding Adaptations☐ Thickened Liquids Consistency:☐ Adapted Utensils Details:☐ Adapted seating Details:☐ Calorie supplements:☐ Tube Feeding Amount: _____ Times per day: _____ ☐ Continuous ☐ Bolus**Areas of Difficulty**☐ Chewing☐ Drooling☐ Transitioning Between Foods☐ Jaw shifts/slides/juts☐ Communication Needs☐ Swallowing☐ Understanding Words**Speech Language****Communication Skills**

Does the child:	Yes	No
Have speech that is understood by most people?		
Respond correctly to yes/no questions?		
Follow simple instructions?		
Respond when name is called?		
Stutter?		
Recognize objects, people, and places?		

Speech Milestones

When did the child begin?	Age (in months)	Milestone	Age (in months)
Babbling		Putting 2 words together	
Saying first words		Using short sentences	
Naming familiar objects			

First Words _____

Augmentative Communication Device _____

Primary Communication Verbal Non-Verbal None

Methods of communication used:

☐ Vocalizations ☐ 2 word Phrases ☐ Facial Expressions ☐ Manual Sign Language ☐ Pointing
☐ Single Words ☐ Complete Sentences ☐ Body Language ☐ Gestures ☐ Eye Gaze

Please describe current speech concerns:

Home Environment

Child lives with: (Please select all that apply)

☐ Birth mother ☐ Step-mother ☐ Siblings
☐ Birth father ☐ Step-father Please list siblings ages: _____
☐ Adoptive mother ☐ Grandmother ☐ Other Relative
☐ Adoptive father ☐ Grandfather Please specify: _____
☐ Legal guardian
Please specify: _____

Additional Comments: _____

Adoption

Age at adoption: _____

Additional Details: _____

Type of Home

☐ Single Level ☐ Assisted Living Facility
☐ 2 Level ☐ Skilled Nursing Facility
☐ Ground Floor Apartment ☐ Group Home
☐ Upper Level Apartment ☐ Other _____

Accessibility

Stairs to get into home: _____ Handrail? ☐ Right ☐ Left ☐ None ☐
Ramp to get into home? Yes No
Stairs in home: _____ Handrail? ☐ Right ☐ Left ☐ None ☐

☐ Bathroom on Main Level ☐ Bedroom on Main Level
☐ Bathroom on Upper Level ☐ Bedroom on Upper Level

Additional Comments: _____

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:				

Describe any home program that is currently performed (e.g. stretching, strengthening, brushing, etc)

Describe any community groups or sports activities the child is involved in:

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

Does your child have an IFSP? ☐ Yes ☐ No

Does your child have an IEP from school? ☐ Yes ☐ No

Has your child had a psychological or neuropsychological evaluation completed? ☐ Yes ☐ No

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:				

Additional Comments: _____