COORDINATED MOVEMENTS, INC.
29770 Three Notch Road, Suite 201
Charlotte Hall, MD 20622
(301) 290-0800
(301) 290-1313 Fax

New Patient Y / N
Existing Patient Y / N
Change of information Y / N

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name:_____
Male:_____ Female:_____ Date of Birth:_____
Allergies:_____
Primary Care Physician:_____ Telephone:_____
Referring Physician:_____ Telephone:_____
Reason for Referral:_____
Patient Status: Single____ Married____ Other____ Employed____ PT Student____ FT Student____
Race: American Indian____ Alaskan Native____ Asian____ Black____ White____ Other____
Ethnicity: Hispanic____ Non-Hispanic ____

RESPONSIBLE PARTY INFORMATION

Mother's Name:_____ Telephone:_____
Address:_____
City:_____ State:_____ Zip Code_____
Work Phone:_____ Cell Phone:_____
Father's Name:_____ Telephone:_____
Address:_____
City:_____ State:_____ Zip Code_____
Work Phone:_____ Cell Phone:_____

INSURANCE INFORMATION

Primary Insurance Name:_____
ID #_____ Group #_____
Subscriber's Name:_____
Race: American Indian____ Alaskan Native____ Asian____ Black____ Caucasian____ Other____
Ethnicity: Hispanic____ Non-Hispanic ____
Relationship to patient:_____ Subscriber's Date of Birth:_____
Employer:_____ Telephone:_____
Employer Address:_____

Secondary insurance is the responsibility of the patient to file with their insurance company. Coordinated Movements, Inc. **does not** bill secondary insurance.

ACCIDENT RELATED CONDITION

Employment Related: Yes____ No____ Accident Related: Yes____ No____
Accident State:_____ Date of Injury_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Coordinated Movements, Inc. to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance company denies payment. Patients are responsible for any deductible and coinsurance and uncovered charges at the time services are rendered.

I also give permission for my medical status, treatment and bills to be discussed with other healthcare providers involved in my care, family members, and attorneys, insurance companies with whom I have coverage and my attorney's office in the event that it is requested.

I acknowledge I have received a copy of the "HIPPA Notice of Privacy Practices" and understand my rights regarding my health information.

Signature of Patient of Legal Guardian:_____ Date:_____

Financial Policy

Coordinated Movements, Inc. will be billing your insurance company directly for your occupational, physical and / or speech therapy treatment. You are responsible for all co-payment or any deductible after each treatment. Every effort will be made to bill your health insurance company and receive payment, but ultimately the responsibility of payment in full is up to each patient or guarantor for their occupational, physical and / or speech therapy treatment. Statement will be sent for any outstanding balance as needed and payment is expected upon receipt. There will be a $35.00 fee for all written reports (other than standard evaluations) and photocopies; and a two-week notice is required for these documents. Additionally, there will be a $25.00 fee charged for any returned checks.

Worker's Compensation: Coordinated Movements, Inc. is obligated by law to accept payment in full for occupational, physical and / or speech therapy treatment from worker's compensation insurance.

Blue Cross Blue Shield PPN: Coordinated Movements, Inc. is a participating provider with BCBS and their preferred provider network program. We agree to accept the allowed benefit as payment for occupational, physical and / or speech therapy treatment. The deductible and co-payment are the responsibility of the patient or guarantor.

Other Insurance Companies & HMO's: Coordinated Movements, Inc. will bill your insurance company for services rendered. The deductible and co-pay is responsibility of the patient or guarantor.

I certify that I have read the above information relating to the Financial Policy for Coordinated Movements, Inc. and except the terms explained in the Financial Policy. INITIAL & DATE _____

Cancellation Policy

Coordinated Movements, Inc. wants to see continued improvement in your occupational, physical and speech therapy. In order for this to happen, appointments must be kept. If you are unable to keep your therapy appointments PLEASE call within 24 hours and we will attempt to reschedule another appointment. Attendance to therapy is crucial to your child's progress for multiple reasons. First and foremost, consistency will provide your child with the maximum benefit from therapy. Repeated cancellations such as canceling 2 out of 4 appointments will impact your child's progress. Secondly, insurance companies review your child's progress and without attendance your child's progress will be delayed. This may lead to your insurance company denying continued therapy services.

Due to the high cancellation rate, the following cancellation policy will be implemented and enforced:

A NO SHOW, with no call prior to the scheduled appointment time, will result in a **$25.00** fee applied to your account. The **$25.00** fee must be paid prior to your child receiving their next scheduled therapy appointment. This will be strictly enforced. Repeated cancellations will result in your child being placed at the bottom of the waiting list. INITIAL & DATE _____

Weather Policy

Beginning January 23, 2015, Coordinated Movements will follow the St. Mary's County Public School's decision on opening for inclement weather. **If St. Mary's School System makes the decision to close secondary to weather conditions, Coordinated Movements will be closed. If St. Mary's School System makes the decision to open 2 hours late secondary to weather conditions, Coordinated Movements will open at 10 a.m.**
By 5:45 a.m. a message will be left on the office answering machine stating Coordinated Movements opening plans based on the decision made by St. Mary's County Public Schools.
Coordinated Movements office number 301-290-0800.

INITIAL & DATE _____

Signature of Patient or Legal Guardian:_____
Date:_____

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Client and any minor client's parent/legal guardian (s), accepts and ASSUMES THE RISK of treatment and RELEASES Coordinated Movements, Inc., its officers and other agents from all claims of any nature, except those claims which may not be released pursuant to law. Coordinated Movements, Inc. is not responsible for ascertaining historical physical condition and capabilities. Accordingly, client and/or any minor clients parent/legal guardian represents and warrant that if client ever had [seizures, RSV, allergies, heart or respiratory condition, diabetes] and/or any other physical quality that may negatively affect or be material information relating to treatment, then Client or any minor Client's parent/legal guardian (s) will notify the staff that fact in writing, as well as obtained the specific approval of a physician before obtaining services.

Signature of Client Legal Guardian:_____

Date:_____

Child's Name: _____

Date: _____

By signing below, I authorize Coordinated Movements, Inc. to photograph and / or video tape my child during his / her treatment session. I am aware that all photographs and video will be presented by a Licensed and / or Certified Coordinated Movements, Inc. staff member (s) for **educational purposes** only.

Parent / Guardian Signature:_____

Child's Name: _____

Date: _____

By signing below, I authorize Coordinated Movements, Inc. to photograph my child during his / her treatment session. I am aware that photographs may be used in Coordinated Movements, Inc. **Newsletters** and on the Coordinated Movements, Inc. **website.**

Parent / Guardian Signature:_____

Please fill in your email address below if you would like to be on our email list to receive newsletters and information about upcoming programs.

EMAIL ADDRESS:_____

PRENATAL HISTORY

Previous pregnancies (number and problems)_____

_____

History of pregnancy with this child (medications, complications, etc.)_____

_____

Length of pregnancy and labor_____

_____

Type of delivery (complications if any)_____

_____

EARLY HISTORY

APGAR Scores_____ Weight_____ Height_____

Breast Fed? Y / N How long?_____ Strong suck? Y / N Spit up frequently? Y / N

Problems with feeding / respiration / sleeping (circle and describe)_____

_____

_____

_____

Irritable / Happy / Quiet Baby? (Circle) Did baby arch back and head when upset? Y / N

MEDICAL HISTORY

Hospitalizations_____

Surgeries_____

Seizures_____ Ear Infection_____

Special Diet_____ Glasses_____

Medications (please list)_____

Past Medical Evaluations (Neurologist, Orthopedist, Behavioral Specialist, Psychologist, etc.):

_____

_____

DEVELOPMENTAL MILESTONES

(Please note approximate age at which he / she did the following)

Sat_____ Belly Crawled_____ Crawled_____ Cruised_____ Walked_____

First Word_____ Talked_____ Toilet Trained: (bladder)_____ (bowels)_____

Undressed self_____ Dressed self_____ Managed snaps, zippers, buttons_____

Tied shoes_____ Started Preschool_____ Hand dominance_____ L / R

Social History

Siblings? Y / N

Name & Age_____
Name & Age_____
Name & Age_____

Please note if sibling has / had any similar problems:_____
_____
_____

School Attended_____ Grade_____
Teacher's Name_____ Telephone_____
School therapies and services_____
Special interest of child (hobbies / sports / programs)_____

Present Status

Any unusual behavior (i.e. hand banging, temper tantrums, rocking, breath holding, etc.)_____
_____
_____

Hyperactive? Y / N
Restless? Y / N

Inattentive? Y / N
Easily Frustrated? Y / N

Distractible? Y / N
Average Attention Span____

Describe interaction with others:_____

In groups does your child get excited easily?_____

Is your child easier to handle in small groups or individually?_____

Enjoys other children?_____

Plays along side others or interacts and participates with others during play? (Circle)

Type of specialized equipment your child requires_____

Self Help Skills

Manipulate clothing fasteners? (buttons, zippers, snaps) List any difficulties:_____
_____

During feeding – uses spoon / fork, knife (circle) List any difficulties:_____

Drinks from bottle / sippy cup / open cup? (circle)

Independent with hand washing? Y / N
Independent with brushing teeth? Y / N

Independent with bathing? Y / N
Independent with grooming? Y / N