Patient Registration Form – Pediatric Patient (newborn to 11yrs)

Patient Name:	Date of birth:	
Preferred:		
Address, City, State, Zip:		
Parent/Guardian Information		
1st Parent/Guardian name:	Contact number:	
Address if different form above:		
2nd Parent /Guardian name:	Contact number:	
Address if different from above		
Home Phone: Work phone:		Appointment Reminder Method
Cell Phone:		☐ Home Phone ☐ Cell Phone/Text
Email address:		☐ Work Phone ☐ Email
2nd Contact name/address:		
2nd contact phone:	Relation:	
Pediatrician/Physician:	Referred by:	

INSURANCE INFORMATION Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible to provide their most current insurance information.

Primary Insurance:		Secondary Insurance:	
Group #	Policy #	Group #	Policy #
Insured Information:		Insured Information:	

Consent to Treat/Assignment of Benefits/Acknowledgements

I hereby authorize and consent to treatment/services for myself, or on behalf of the above-named patient performed by the staff at HPRC Physical Therapy and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.

I assign payment for these services directly to HPRC Physical Therapy. I authorize the filing of claims to my insurance plan and authorize HPRC Physical Therapy to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.

In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believe were covered services, resulting in my responsibility for paying for these services.

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Print Name Relationship to the Patient

Patient name: **DOB:**

Authorization for Communication

By providing my above contact information and signing below, I consent and authorize HPRC Physical Therapy and its related entities, agents, contractors, including but not limited to scheduling, billing, and other departments to use automated telephone dialing systems, SMS text messaging, (if opted in) and electronic mail to (1) provide messages (including prerecorded messages or text messages, (if opted in)) to me about appointment reminders, patient surveys, my account, payment due dates, missed payments, information for or related to medical goods and/or therapy services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message, (if opted in) that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that providing a telephone number and/or email address is not a condition of receiving medical services.

I also understand that I may revoke my consent to contact at any time by directly contacting HPRC Physical Therapy or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify HPRC Physical Therapy immediately of any change in telephone number or email address.

Please check the box below to opt in to receive messaging.

☐ **I consent** to receiving text messages about care, appointment reminders, and important health reminders from HPRC Physical Therapy at the phone number I provided. I acknowledge that my consent is not a condition of purchase. Message & data rates may apply. Message frequency varies. You can reply HELP for support or STOP to opt out of receiving messages. To learn more about how we handle your data please view our privacy policy here. https://hprc.net/wp-content/uploads/sites/20/2026/01/HPRC-Website-Privacy-Policy-Terms-11-2025.pdf

☐ **I do not** consent to receiving text messages.

Patient/Guardian Signature: Date:

Release of Information

I hereby authorized HPRC Physical Therapy to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis and/or billing and payment for services rendered on my behalf to the person(s) listed below.

Name (print)	Relationship	Phone number
Name (print)	Relationship	Phone number
Name (print)	Relationship	Phone number

Patient/Guardian Signature: Date:

Financial Policy

Payment for services is due at the time services are rendered

We will verify your benefits with your insurance carrier. However, this does not guarantee that they will cover the prescribed treatment. By signing below, you are acknowledging that you are responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance carrier and understand that you are fully responsible for any balance due for services rendered.

Patient/Guardian Signature: Date:

Patient name:	**DOB:**

Cancellation/No Show Policy and Fee Acknowledgement

It is the policy of HPRC Physical Therapy to monitor and manage appointment no-shows and late cancellations. Regular attendance at therapy sessions is crucial for you to recover fully and return to the activities you love. When an appointment is missed, it's a missed opportunity for progress in your recovery, and it impacts our ability to accommodate other patients who may need urgent care.

If you need to cancel or reschedule, please call the clinic.

Scheduled appointments must be cancelled or rescheduled at least 24 hours prior.

Failure to attend your appointment without 24-hour notice may result in a fee of $50 that will be charged directly to you as the patient (not insurance) for each instance of a missed appointment.

_____ _____

Signature of patient/authorized representative Date

_____ _____

Printed name Relationship to patient

HPRC PHYSICAL THERAPY

PEDIATRIC PATIENT HEALTH QUESTIONNAIRE	
Patient name:	**DOB:**
Lives with both parents? ☐Yes ☐No If not, with whom does child live most of the time?	
Siblings - Name, ages, and any history of delays:	
Is this child: ☐Biological ☐Adopted Height: Weight:	Sex: ☐ Male ☐ Female
Please indicate – Length of pregnancy:	Birth weight:
Notable circumstances during pregnancy, labor, deliver, and/or following birth:	
List any precautions you would like for us to know.	
Please list specialist/physicians seen, including dates, names, specialty.	
List any special tests (x-ray, MRI, etc.) including dates.	
Please list any known allergies (including medications, latex, etc.) below.	
Has your child had a vision test/screening? ☐Yes ☐No Date:	Results:
Please indicate if your child has had the following vaccinations: **MMR:** ☐Yes ☐No **Hepatitis:** ☐Yes ☐No **Chicken Pox:** ☐Yes ☐No	

Please mark any of the following illnesses that are common conditions in your child – list approximate age out beside the condition listed.

Allergies	☐Yes ☐No	Headaches	☐Yes ☐No
Asthma	☐Yes ☐No	High Fever	☐Yes ☐No
Chicken Pox	☐Yes ☐No	Measles	☐Yes ☐No
Colds	☐Yes ☐No	Seizures	☐Yes ☐No
Croup	☐Yes ☐No	Tonsillitis/Adenoids	☐Yes ☐No
Ear Infections	☐Yes ☐No	Other, please list	☐Yes ☐No

Please list current medications and for what condition (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.

Name	Dosage	Frequency	Condition

Surgery / Hospitalization, please include date and reason.	

List any significant illnesses.

Patient name:			**DOB:**
Developmental History – please indicate at what age your child achieved the following developmental milestones			
Babbling		Sitting	
Crawling		Standing	
Combining Words		Toilet Training	
Single Words		Walking	
Describe general coordination:			
Are there currently or have there been any feeding problems (i.e., sucking, swallowing, drooling, chewing, extreme picking eating, etc.)? Please explain			
Describe your child's current vocabulary.			
How many words is he/she using? ☐ 100-1000+ ☐ 100's ☐ 50-100 ☐ 25-50 ☐ 10-25 ☐ 10 or less			
If nonverbal, how does he/she communicate?			
Language spoken at home?			
Describe social language skills.			

Educational History
School: Grade:
Please indicate your child's school schedule (i.e., days, times, etc.)
Describe your child's school performance.
What, if any, special services does your child receive at school?
Previous Assessments and Therapies
Please list any developmental therapies or interventions your child has participated in or is currently participating in, include dates. (OT, PT, SLT, music therapy, counseling, etc.)
Social and Other Information
Interest/Hobbies.
Describe peer relations.
Describe your child's most concerning/challenging behaviors.
Does your child have any textures they like or dislike?
My child's fears are:
What works to motivate or reward your child?
What other information would you like for us to know about your child that would aid in their evaluation/treatment?
Prioritize your top 3 concerns you want to be sure we address in this evaluation and/or therapy?
1.
2.
3.

I certify the above information is correct to the best of my knowledge and will advise the therapist if there is any change in the information provided above.

Signature: _____ Date: _____