Artistic Athletics Physical Therapy and Performance
994 Brodhead Road, Moon Township, PA 15108

Registration Instructions:

You will need the following information:

- Name of insurance company — Policy type (HMO,PPO)
- Primary policy holder's name — Policy holder's DOB
- Policy holder's phone number
- Child's name — Child's DOB

MUST BE COMPLETED IN ORDER TO SCHEDULE FIRST VISIT!

Please email to **apttalia@gmail.com**, **fax 412-264-0868**

- New Patient Intake form completed
- Copy of insurance card and photo ID **front and back** for verification of insurance benefits (for those billing insurance)
- Registration paperwork fully completed **and signed**
- Incomplete paperwork or missing information may result in postponement of your child's visit/care

IMPORTANT BILLING AND INSURANCE INFORMATION:

* *As a courtesy to you, we will verify your insurance benefits. However, it is YOUR responsibility to make sure they are correct.*
* *For your convenience, we now take credit cards! We can swipe at the gym, if you prefer.* **Payment is due the date of service! Please fill out the credit card form, or bring payment to each appointment!**
* *You can also make checks payable to:* ***Artistic Athletics PT and Performance***

If your child needs to cancel for any reason, please contact us via phone/text as soon as possible to let us know! The second No Show will result in fee of $25

Talia 412-303-9957 or apttalia@gmail.com (Xcel, AllStar, Gymsport)

Stephanie 585-739-4749 or aptsteph@gmail.com (Jewarts)

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New Patient Intake Form

Today's Date	Information Taken By	Date of 1st Visit	Time
Patient Name			Date of Birth
Address			
City		State	Zip Code
Home Phone	Cell Phone	Work Phone	
Email		How Did You Hear About Us	
Patient's Primary Contact ***(if applicable)***		Phone	
Primary Care Physician	Referring MD		
Diagnosis/Reason for Treatment			Direct Access Yes No
Any Previous Therapy Treatment for this Injury? Yes No	If Yes, When?		
Primary Insurance	Member #	Insurance Phone	
Subscriber Name		Subscriber Date of Birth	

Notes:

OTHER PHYSICIAN INFORMATION

**If you were not referred by a physician, we prefer to send our evaluations to your child's physician (ie, pediatrician, PCP) in order to keep them notified of their patient's health. When the DR agrees to our plan of care, this also allows us to the opportunity to treat your child without a prescription for longer than 30days if needed. Please sign your consent to do this, and provide the information below:*

Yes, please send my child's evaluations to the DR listed below:

Signature______________________________ Date____________________

*Physician Name*____

Practice Name__________________________Location________________

Phone #_______________________________Fax #__________________

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PATIENT HISTORY

Name______________________________Gym_________________________

Age_____Age started gymnastics_____ Years on competitive team______

Current Level_______How many yrs at that level______________________

Recent Growth Spurt? Y/N, how much?______________________________

Do you see any other healthcare professionals on a regular basis? (ie, chiropractor, rheumatologist, etc) If yes, please explain below:

____

CURRENT INJURY INFORMATION

Injury type/location/diagnosis_______________________________________

When/how did the injury occur?_____________________________________

Pain level best to worse (0=none, 10=worst possible)__________________

What makes your symptoms worse__________________________________

What makes your symptoms better__________________________________

Are you currently participating in phys ed class?________________________

Are you currently able to participate in gymnastics?____________________

Any imaging performed for this injury?________________________________

Are you currently taking ANY medications?____________________________

List any allergies, precautions______________________________________

List all previous injuries____

List any Medical Conditions____

I declare the above information I have supplied is true, complete, accurate, and current to the best of my knowledge.

____________________________________ ___________________________

Signature of Patient or Legally Responsible Person **Date**

apttalia@gmail.com

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fax 412-264-0868

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COMMUNICATION CONSENT

I give consent to Talia Trapuzzano Eubanks, PT, DPT, SCS, ATC, Stephanie Straub, MSPT, and other staff involved with my child's physical therapy care to communicate with me, my child, his/her coaches, and referring physician through non-secure electronic correspondence for the purpose of discussing medical condition and treatment only. I am aware that information communicated in such ways may contain protected health information.

I also give consent for Talia Trapuzzano Eubanks, PT, DPT, SCS, ATC and Stephanie Straub, MSPT to contact my child via their private cell phone through text messaging, email or other means of electronic correspondence for the means of setting up scheduling and checking on my child's health only.

Please add **apttalia@gmail.com** and **aptsteph@gmail.com** to your address book to ensure emails do not get sent to your spam folder.

PARENT INFORMATION

Cell phone #____Text Messaging: YES NO

Email____

PATIENT/CHILD INFORMATION

Cell phone #____Text Messaging: YES NO

Email____

DIGITAL MEDIA AUTHORIZATION AND CONSENT.

I am aware that individual photos or videos may be taken of my child for Physical Therapy treatment purposes and may be stored on devices, including smartphones, tablets, computers, or other electronic devices. I authorize the release of this digital media for Clinical purposes which may be used for educational presentations, writing, or Physical Therapy treatment; Media/Marketing that may be used for advertising included but not limited to written publications, social media, and the internet. I hereby grant my child's likeness to be used without compensation. I consent that in regards to photographs for advertising my child's HIPPA compliance may be breeched.

CONSENT FOR EMERGENCY CONTACT INFORMATION

(Person to contact in case of emergency):

____ _________________________

Name/Relationship Phone #

By signing below, I certify that I have read, fully understand and agree to each of the above statements in this document and I voluntarily affix my name in agreement.

____ _________________________

Signature of Patient or Legally Responsible Person Date

____ _________________________

Printed Name of Person Above Date

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CONSENT,LIABILITY,AND STATEMENT OF FINANCIAL RESPONSIBILITY

1. CONSENT FOR TREATMENT. I hereby consent to and authorize my physical therapist and their affiliates, to provide me with care and treatment as necessary. I acknowledge that no guarantees have been made to me about the results of treatment.

2. RESPONSIBILITY OF PAYMENT. I acknowledge that in consideration of the services provided to me by Artistic Athletics Physical Therapy and Performance, LLC, I am financially responsible for payment of my bill. I understand that is is my responsible to provide accurate and current insurance information and to familiarize myself with my insurance plans, policies, and coverage. Any questions I have regarding specifics of my health insurance plan or benefits should be directed to my health plan provider. My health insurance plan my state that a portion of the charges and balance may remain my personal responsibility; such as deductibles, co-insurance, co-payment, or charges not covered or denied by my health insurance. I understand that I have the right to revoke my child from physical therapy services at any time. I also have the right to revoke my insurance consent at any time by contacting the provider for my child and indicating in writing that I no longer consent to use of my child's insurance benefits and/or no longer want my child to receive Physical Therapy services. However, I understand that any balance for services received prior to the point of cease of services or use of insurance benefits is due IN FULL immediately.
Please note that refusal to sign this form does not change my responsibility for payment in any way.

3. ASSIGNMENT OF BENEFITS. I hereby assign Artistic Athletics Physical Therapy and Performance, LLC and all of my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits. I understand that a quotation of benefits form my private insurance company is not a guarantee of payment.

4. PERSONAL LIABILITY. I understand that severe injuries, including permanent paralysis or death, can occur during any activity involving height or motion, those activities include but are not limited to gymnastics, tumbling, trampoline, dance, cheerleading, ball sports, and therapy services. Being fully aware of these dangers, I hereby give consent for my child to participate in any and all activities necessary for Physical Therapy treatment with Artistic Athletics Physical Therapy and Performance, LLC and by treating physical therapists Talia Trapuzzano Eubanks, PT, DPT, SCS, ATC and Stephanie Straub, MSPT. I accept all risks associated with such participation. In consideration for me and my child, I hereby promise not to sue and forever release Artistic Athletics Physical Therapy and Performance, LLC, Talia Trapuzzano Eubanks, PT, DPT,SCS, ATC and Stephanie Straub, MSPT from all liability resulting from damage or injuries incurred as a result of participation including those resulting from acts of negligence. In the event of an accident or emergency, I hereby authorize may child to receive CPR from an individual that upholds a current CPR and AED certification. I also authorize my child to be transported for medial treatment and I hold Artistic Athletics Physical Therapy and Performance, LLC, Talia Trapuzzano Eubanks, PT,DPT, SCS, ATC and Stephanie Straub, MSPT harmless in execution of such. Additionally, I agree to individually provide for all medial expenses which may be incurred by myself or my child as a result of any injury sustained while participating in Physical Therapy.

5. ACCESS TO AND RELEASE OF HEALTH INFORMATION. I understand that Artistic Athletics Physical Therapy and Performance, Talia Trapuzzano Eubanks, PT, DPT, SCS, ATC and Stephanie Straub, MSPT have gathered information related to my treatment in electronic and other forms of payment purposes and to support those who are caring for me. I authorize my Physical Therapist, Redoc, and PBI administrative staff to contact other healthcare professional that may have information related to my prior or current health conditions and treatment.

7. HIPPA AUTHORIZATION. In compliance with HIPPA regulations, I authorize the following individuals to receive verbal information regarding the billing of my account.

______________________________ ______________________________
Name/Relationship Name/Relationship

By signing below, I certify that I have read, fully understand and agree to each of the above statements in this document and I voluntarily affix my name in agreement.

______________________________ ____________________
Signature of Patient or Legally Responsible Person Date

______________________________ ____________________
Printed Name of Person Above Date

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WE WANT TO STAY CONNECTED WITH YOU AND SHARE INTERESTING INFORMATION!

In an effort to stay connected to our patients, Artistic Athletics Physical Therapy and Performance has established a monthly newsletter. Topics that will be covered include: Injury Prevention, Current research, community events, and special offers (exclusive to our patients). The information you filled out above will be used solely for the purpose of Artistic Athletics Physical Therapy and Performance and at no time will this information be given or shared with any outside party.

Name (Printed): ______________________________ Date: ____________

Parent/ Guardian: ____________________________
(if under 18)

Signature: ___________________________________
(if under 18 - parent signature)

Email Address: ____

☐ YES! SIGN ME UP to send me email updates!

☐ No thank you, at this time, I do not want to receive email updates.

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