CHAUX
PHYSICAL THERAPY

PARENT QUESTIONNAIRE

Please return as your earliest convenience

The information you give me will help me to understand your child and to better plan for his or her visit. Not all questions may apply to your child. Please print a copy, complete and fax or mail to my clinic. If you do not send it ahead of time, please bring the completed form with you to the evaluation.

Child's name: _____Date of birth: _____

Parent/Guardian names:_____

Address:_____City:_____State:____Zip:_____

Phone Number:_____Email Address:_____

Occupation:_____

Emergency Contact:_____Phone number:_____

Please tell us kindly who referred you to us:_____

_____

1. What are your goals for physical therapy services?

2. Did your child experience any complications during pregnancy, birth or infancy? If yes, please describe.

3. Has your child been able to roll, sit, crawl, walk, run, and jump as expected for their age?

4. Has your child experienced any significant medical conditions, injuries, or illnesses? Please list.

5. Does your child currently receive any therapy services or have they received services in the past?

6. Is your child being followed by any specialists (i.e. neurology, orthopedics, oncology)

7. Is your child physically active? What activities does your child enjoy? (2 of 2)

8. Do you have any concerns about your child's overall health and nutrition?

9. How much sleep does your child get each night?

10. Who lives in the home with the child?

11. Does your child attend daycare/school?

12. Is there anything else you would like us to know about your child?

Please return this questionnaire before your appointment to help me plan a thorough evaluation. It may be returned in person, by mail, or by fax to:

Chaux Physical Therapy 275 East Hillcrest Drive, Suite 213, Thousand Oaks CA, Phone: (805) 203-9940, Fax: (818) 337-7468

Informed Consent for Physical Therapy

Physical therapy involves the use of many different types of physical evaluation and treatment. At Chaux Physical Therapy, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your responses to a certain therapy modality or procedure. We are not able to guarantee precisely what your reactions to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I acknowledged that my treatment program has been explained by Chaux Physical Therapy, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Chaux Physical Therapy as outlined to me, and I wish to proceed.

_____	_____	_____
Patient Name	Patient Signature	Date

Private Notice

HIPAA AND NOTICE OF PRIVACY PRACTICES

I understand that Chaux Physical Therapy may use or disclose my personal health information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment.

I understand that I have the right to restrict how my PHI is used and disclosed for treatment, payment and administrative operations if I notify the practice.

I also understand that Chaux Physical Therapy will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my PHI for purposes as noted in Chaux Physical Therapy Notice of Privacy Practices, which is displayed in the reception area and a copy of which is available upon request.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. By signing this form, I am acknowledging receipt of the *Notice of Privacy Practices* for Chaux Physical Therapy.

Name of Patient (Print Clearly)

Signature of Patient Date

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Missed Appointment Policy

We appreciate you greatly as our patient and strive to accomplish optimal results and success for you. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

With the exception of serious emergencies, it is expected that you keep all your appointments. If you need to reschedule an appointment, please call our office and arrange for a make-up appointment within the same week. We reserve the right to charge you a $75 no-show fee for canceling an appointment without 24-hour notice or a no-show to a scheduled appointment.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care. Your physician will be informed that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

Late Arrival Policy

In consideration of other patients, your appointment time cannot be extended if you do not arrive on time.
The therapist will determine if there is sufficient time to render quality care in the time remaining for your scheduled appointment. If you are more than 10 minutes late, the therapist may determine that there is insufficient time to provide proper treatment, and you may be charged our $75 missed appointment fee.

_____	_____	_____
Patient Name	Signature	Date