PATIENT SERVICES
ACKNOWLEDGMENT & AGREEMENT

CONSENT FOR CARE AND TREATMENT
I, the undersigned, having legal authority to do so, do hereby agree and give consent for *Lil' Peanuts Physical Therapy,P.C.("LPPT")* to furnish medical care and therapeutic treatment as considered necessary and proper in diagnosing or treating my/his/her condition.

We at Lil' Peanuts Physical Therapy are committed to providing the best treatment possible for all of our clients at competitive rates. We charge what is usual and customary for our practice area and level of expertise. Our service charges are highly competitive with MediCare/MediCal insurance coverage rates. Please be advised that services rendered are considered "non-covered" by insurance. These services may not be reimbursable by insurance.

- Acquisition of any authorizations or referrals required for services from the insurance carrier or primary care physician will be **the patient's sole responsibility**.
- The patient is responsible for 100% of the billed fees.
- **Payment for services is due in full *before or at* each treatment or evaluation session. Any delay in payment past 24hours after therapeutic services rendered will result in a 20% increase for the next session.**
- At this time, we only accept payments in the form of cash, check, or Zelle made payable to "Lil' Peanuts Physical Therapy, P.C." or "LPPT."

FEES FOR ALL SERVICES RENDERED
- Physical therapy consultations are 10 minutes long, free of charge, and will be done over the phone.
- In-person initial **EVALUATION** will be 60 minutes long and have a fee of **$350**. It will include a detailed report and prescribed exercises, though does not include any additional sessions.
- A travel fee of $15 for every visit that is over 15 miles away from LPPT's Glendale Office.
- Additional therapeutic **TREATMENT** sessions will be billed at **$150/session**. Each session will be 30-45 minutes in length depending on child's tolerance and participation.
- A bundle pack of **4 sessions (1 EVALUATION, 3 TREATMENT sessions)** can be purchased in advance for **$650** with all travel fees waived. Unused treatment sessions expire after 6 months from initial evaluation.
- **Monthly** treatment packets can be paid for in advance: 4 sessions can be purchased for **$550**. Sessions purchased cannot be rolled into the next month and must be used within the month it is purchased.
- Every 6 months after initial evaluation, a **RE-EVALUATION** will be performed which is 30-45 minutes long and **$250**. Its purpose is to update physicians and parents on each child's progress in physical therapy and establish new goals.

- **BRAND NEW "WELL BABY" OPTIONS!**
  Option A: IN PERSON Baby's First Year Wellness Checks (not Superbill applicable). **FOUR sessions for $350**. Provided around baby's 3months, 6 months, 9 months, 12 months, 15 months, or 18 months birthdays (depending on age of initiation) for parents seeking personalized answers on baby's gross motor skills and exercises to promote

milestone achievement. Additional sessions not included in cost. Unused sessions expire within a year after first session. All responsibility is on parents to schedule upcoming well checks as needed. Doctor's prescription for Physical Therapy not required unless there is a medical diagnosis and PT treatment is deemed necessary. Written report not provided.
Option B: ONLINE/EMAIL/TEXT/PHONE Parent Resource Consultations (not Superbill applicable). **$250 Unlimited parent resource assistance for 1 year after signing of contract**. Must be questions relating to child's gross motor development and milestone achievement. Not a substitute for physician medical advice. Child can have medical diagnosis that requires PT interventions and child can be receiving PT elsewhere. Written reports will not be provided. Therapist's main purpose is to be another resource for parents to ask questions related to physical development and exercises/activities to facilitate optimal development, often as a second opinion. Therapist will be available within 24-48 business hours to answer any questions parents may have throughout the year. Parents must reside in state of California.

SCHEDULING AND CANCELLATION POLICY
Nonrefundable Deposit Policy
To reserve and hold an initial physical therapy appointment, **a nonrefundable $75 deposit** is required at the time of booking. This deposit will be applied toward the cost of your first session. The deposit is necessary to secure your appointment time and is not refundable in the event of cancellation, rescheduling, or no-show. Sessions are scheduled specifically for you and your baby, and this policy helps ensure availability and continuity of care.

Payment for the deposit can be made via Zelle to (314) 398- 8284.

Scan this code in your bank's app to pay
LIL' PEANUTS PHYSICAL THERAPY, P.C.
xxxxxx8284

Zelle®

☐ **Acknowledgment**
I acknowledge that I have read and understand the nonrefundable deposit policy. I understand that the deposit is required to secure my appointment and will be applied to my first physical therapy session, and that it is nonrefundable under any circumstances.

Parent Name: _____
Signature: _____
Date: _____

If you cannot attend your scheduled appointment time, we ask that you notify us at least **24 hours prior** to your appointment so we may accommodate other patients. Consistency in treatment is important to your therapy outcome and multiple late cancellations may result in termination of your treatment or a loss of desired schedule time. There will be a $50 cancellation charge for sessions cancelled with less than 24 hours' notice.

As a precaution, please do not bring your child to therapy if he or she has a fever, cough, runny nose, diarrhea, skin rash, or any communicable disease. This is a courtesy to our other clients and family members that may come in contact with the same equipment as your child.

SPECIAL BILLING CIRCUMSTANCES
I understand that I have:

- Requested services that are outside of my insurance company's network.
- Knowingly requested services that are my 'out of pocket' financial responsibility.
- The responsibility of requesting a Superbill to submit to insurance for reimbursement at the end of **each** session

PATIENT IDENTITY
My signature below means that I have given truthful information about my name and identity and my child's name and identity. It also means that I understand:
□- How important it is to provide truthful information about my child's condition
□- That incorrect or false information about my child's condition can lead to treatment that could harm him/her.

By signing this document, I acknowledge that I have read, understand, and agree to the foregoing. I also understand that I am solely and directly responsible for the full payment of all fees charged by *Lil' Peanuts Physical Therapy, PC,* regardless of any insurance coverage.

SIGNATURE:_____
DATE:_____

PRINT NAME:_____
CHILD'S NAME:_____

CONSENT FOR RELEASE OF INFORMATION

1) I hereby authorize Lil' Peanuts Physical Therapy, PC, to contact the following health care providers and obtain from these providers all information relating to my child (written or otherwise) which, in the opinion of LPPT, will assist LPPT in their evaluation and treatment of my child. Such information may include, without limitations, "individually identifiable health information" as defined and provided in the Health Insurance Portability and Accountability Act. In addition, I hereby authorize LPPT to share reports and progress with the professionals listed below, including those obtained by caregivers, educators, or relatives involved in my child's care.

Provider Name:
Title: Pediatrician Phone Number:

Provider Name:
Title: Physical Therapist Phone Number:

Provider Name:
Title: Phone Number:

Parent/Guardian's Signature: _____ Date:_____
Relationship to child: _____

2) I understand that LPPT has an online and on campus presence for education and promotional purposes. An important way to educate the general public on conditions treatable by Physical Therapy is through sharing of information with other parents in need. I understand that if LPPT decides to use an image of my child in therapy for education purposes, identifiable characteristics will be kept to a minimum unless specific permission from me is attained. I also understand that if I provide my signature below, then I am allowing LPPT to use photographic representations of my child's therapy. However, I will choose to:

[ ] Only allowing LPPT to use videos/photographs that **does not** show my child's face.
[ ] Only showing the treatment room and/or treatment techniques set up for my child.
[ ] LPPT can show any portion of treatment for education purposes, including my child.

Parent/Guardian's Signature: _____ Date:_____

3) An important way to promote pediatric PT as a profession is by allowing graduate students to participate in hands-on activities with patients. I understand that LPPT strives to be the go-to pediatric physical therapy expert and my contributions will directly contribute to the success of physical therapy as a profession and LPPT as a small business. I will be notified if a student observer would like to participate in my child's PT session.

[ ] Please sign below if you **DO NOT** allow any observational visits from PT students as part of your treatment with Lil' Peanuts PT.

Parent/Guardian's Signature: _____ Date:_____

4) I understand that, if I provide my signature below, I have agreed for LPPT to use any measurements or evaluation findings as part of a future case study or research study that may contribute to scientific research of certain pediatric conditions that may affect development. If LPPT choose to include my child

in any future data collection, any identifiable characters will be excluded. If my child's physical therapy measurements and data are used in any research in the future, I will be given a signed and dated copy of this form to keep, along with any other printed materials deemed necessary by the study investigators.
Subject's Name (print): _____
Subject's Signature:_____ Date: _____

Direct Access Disclosure

You (the patient) are receiving direct physical therapy treatment services from an individual who is a physical therapist (PT) licensed by the Physical Therapy Board of California. Your physical therapist is a professional employee, partner, or owner in this physical therapy practice, which will bill the patient for professional physical therapy services recommended and administered by the PT in the best interests of your personal health.

Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

With your written authorization, your physical therapist shall notify your physician and surgeon, if any, that he/she is treating you.

Patient signature: _____

GENERAL WAIVER AND RELEASE
FOR PARENTS OR LEGAL GUARDIANS OF PATIENTS

I, _____, the parent or legal guardian of _____(hereinafter "Patient"), with the birthdate of _____, on behalf of myself and Patient, have authorized Lil' Peanuts Physical Therapy, P.C. ("LPPT") to provide Patient with certain agreed-upon pediatric therapy services. I voluntarily consent to the professional recommendations, evaluation, and/or treatment offered by LPPT. I acknowledge that neither LPPT nor any of its agents have made any guaranty or promise to me about the results of these therapy services. I further acknowledge and agree that the success of such therapy services greatly depends on Patient's and parents' and/or guardians' level of commitment, motivation, and adherence to the advice or suggestions given during therapy and how more generally, Patient responds to the therapy, and for these reasons, LPPT cannot guarantee the outcome of any procedures or treatment. I understand my right to know all treatment purposes, risks, benefits, and alternatives, and I acknowledge and understand that I will be given ample opportunity to ask any questions of LPPT regarding any and all of these issues or matters before any such procedures or treatment is provided.

I further understand and agree that there may be risks or hazards associated with the therapy services which LPPT provides and/or associated with the behavior of other children to which Patient may be exposed to during therapy, and I acknowledge that I have had an opportunity to ask any questions I may have and to receive answers concerning those risks. I understand that, on behalf of myself and Patient, I am assuming all risks and hazards of loss or injury of any kind whatsoever that may arise in connection with the therapy services provided by LPPT to Patient.

Consistent with the above, I, on behalf of myself and Patient, **waive, release, and hold harmless** LPPT, any related entities, its Board of Directors, shareholders, officers, employees, volunteers, agents, and any independent contractors (hereinafter "the Released Parties") from any and all claims, costs, suits, actions, judgments, and expenses, for or involving damage, loss, or injury to Patient or Patient's property, arising out of Patient's participation in LPPT's therapy services or related treatment. I understand that this General Waiver and Release is intended to be as broad and as inclusive as permitted by the laws of the state of California and agree that if any portion of this General Waiver and Release is held invalid, the remainder of this General Waiver and Release will continue in full legal force and effect.

I affirm that I am of legal age and am freely signing this General Waiver and Release on behalf of myself and Patient. I have read this General Waiver and Release and fully understand that by signing below, I am giving up legal rights and/or remedies which may be available to me or Patient for injury or damage to Patient or Patient's property, arising as a result of Patient receiving therapy services by LPPT, whenever, or however the same may occur. I further acknowledge and agree that I was informed that I have the right to consult with an attorney before signing this General Waiver and Release and that this sentence shall constitute written notice of the right to be advised by legal counsel.

I fully acknowledge and agree that this General Waiver and Release sets forth all of the terms and conditions of the agreement between the Parties concerning the subject matter hereof, and it supersedes any and all prior and/or contemporaneous agreements, understandings, and communications, whether oral or otherwise, regarding such matters. This General Waiver and Release shall be construed and interpreted in accordance with the internal laws of the State of California. Once this General Waiver and Release becomes effective, its terms can only be altered, revoked, or rescinded with the express written agreement of both of the Parties.

Your child's safety is our number one priority at LPPT, therefore our therapists are trained in Cardiopulmonary Resuscitation (CPR) and Basic Life Support (BLS). CPR and BLS techniques will be implemented as needed to ensure the safety of all children, families, and staff.

To ensure the health of all our clients, we ask that if your child is sick and has stayed home from school or daycare, please call or email us to reschedule your child's appointment with us. Therefore we can keep other children and our therapists healthy.

I declare that the foregoing is true and correct, and that it has been signed on this _____day of _____, 20___.

Parent/Guardian's Signature:_____

Printed Name:_____

Address:_____
Apt/Unit #:_____
City, State, Zip Code: _____
Phone:_____

History Intake Form

Name of Child (legal):_____Date of Birth:_____Gender:_____
Pediatrician's Name (First and Last):_____
How did you hear about us?_____

Caregiver's Information #1:

Name:	
Occupation/Title:	Work Phone:
Email:	Best way to contact:

Caregiver's Information #2:

Name:	
Occupation/Title:	Work Phone:
Email:	Best way to contact:

Emergency Contacts (other than caregivers):

Name:	Relationship to Child	Phone Number

Referral Information:

Name:	Relationship to Child	Phone Number

Siblings:

Name:	Gender	Age	Any relevant medical history

Primary Language spoken at home:
Child's Dominant Language:

Pertinent Family Health History (physical, developmental, learning, etc):_____
_____
_____
_____

Why are you seeking this evaluation and physical therapy?_____
_____
_____
_____

Has your child received any special services and/or therapeutic services in the past?
_____

If Yes, Why?_____
If Yes, please include:

Provider Name:	Provider Phone Number:	Service Received:	Dates of Service:	Current Intervention:

Why were services discontinued?_____

What do you hope you and your child will gain from this evaluation and/or therapy?
[ ] I would like more information
[ ] I would like an answer or diagnosis
[ ] Other:

BIRTH HISTORY:
If adopted, please give details including age at time of adoption, surrogacy detail, child's birth country, and if your child knows that he/she is adopted:_____

Was child conceived via artificial reproductive technology? [ ] Yes [ ]No
Did a surrogate carry the child? [ ] Yes [ ]No
Any complications during pregnancy? [ ] Yes [ ]No
If yes, please explain:_____

Medications taken during pregnancy: _____

Born at: ____weeks gestation
Born via: [ ] Vaginal Delivery [ ] C-section [ ] Breech (feet first) [ ] Induced [ ] Face-up

Birth Weight: _____
If C-section: [ ] Planned [ ] Emergency

Any complications during delivery? [ ] Yes [ ]No
If yes, please check any of the following:
[ ] Injury to mother [ ] Anemia [ ] Preeclampsia, eclampsia, or toxemia [ ] Diabetes [ ] Surgery
[ ] Bleeding [ ] High blood pressure [ ] Surgery [ ] Psychological problems or stress [ ] Illness
[ ] Premature placenta separation [ ] Excess vomiting [ ] Fetal distress [ ] Fetal growth restriction

Was your child in the NICU for any period of time? What for? _____

Infant Complications:
As an infant, did your child have any of the following problems? Check all that apply.
[ ] Feeding trouble [ ]Colic [ ]Excessive vomiting [ ]Constipation [ ] Blueness (cyanosis)
[ ] Seizure (convulsions) [ ] Need for oxygen [ ] Breathing trouble [ ] Yellow jaundice
[ ] High fever [ ] Excess diarrhea [ ] Head banging [ ] Slow weight gain [ ] Stiffness

[ ] Chronic ear infections [ ] Excessive irritability [ ] Congenital defect [ ] Heart disease/defect
[ ] Hydrocephalus [ ] Bleeding into brain [ ] Physical abnormality [ ] Other:

Treatments used for an infant complications as indicated above: _____
Allergies/Feeding
Does the child have any allergies to food or medication? [ ] Yes [ ] No
What kind of milk was the child started on? [ ] Breast [ ] Formula
How old was the child when s/he was weaned from the bottle or breast? _____months

DEVELOPMENTAL HISTORY

Developmental Milestones
What age did your child start tummy time?_____
What age did your child start rolling back to front? _____front to back?_____
What age did your child start sitting independently?_____
What age did your child starting crawling on hands and knees? _____
What age did your child start sleeping on the belly?_____
What age did your child start standing independently?_____
What age did your child start walking independently?_____
Any early feeding/sleeping problems?_____
Activity level as an infant: [ ] High [ ] Average [ ] Low

Any developmental concerns? _____
Any regression of skills during development? _____

At what age did you first have concerns about your child's functioning? _____

Please explain all of your concerns that you would like LPPT to address:
_____

Does your child attend day care? Where? _____

Did/does your child spend significant amount of time (more than 15 minutes a day) in any sort of equipment?

[ ] Rock and Play [ ] Bouncer [ ] Swing [ ] Jumper [ ] Walker [ ] Bumbo
[ ] Car seat [ ] Snoo

MEDICAL HISTORY

Please provide all medical contact information (current and previous).

	Name	Phone Number	Date of last visit	Outcome
Pediatrician				
Dentist				
ENT				
Ophthalmologist				

Developmental Optometrist				
Neurologist				
Psychologist/Neuro-Psych				
Social Worker				
Psychiatrist				
Other:				

Does your child have a history of ear infections?_____
Does your child have a history of vision or hearing problems?_____

Please list any previous medical conditions or illnesses that required hospitalization, surgery, or medication:

Please list the date and type of surgeries or hospitalization _____
_____

Have you been told or do you feel like your child may show characteristics of a diagnosis or disability?
_____

Any additional comments:
_____
_____
_____

Thank you so much for your time. Please sign here to acknowledge that all of the above information has been reviewed and is correct.

Parent signature: _____ *Print name:* _____
Child's full name: _____ *Date:* _____