

COVID-19 Policy UPDATE (March 2022):

Dear Parents,

Because we are living in a challenging time, we want to reassure you that we only have your child and family's best interest at heart. Here are some updates to our proceedings that are designed to keep everyone safe:

- 1) I will be masked during every session with your child
- 2) Parents are asked to provide their own spaces, toys, and equipment so I will not be bringing anything to my sessions other than my clipboard and necessary papers, which will be kept away from your child
- 3) Whenever possible, I will have parents perform hands-on guidance of babies and I will maintain 6ft distance from others in the home.
- 4) I have now completed my Moderna vaccine and booster against COVID-19.

Please see attached for our new patient agreement and do not hesitate to let me know if you have other suggestions or requirements. I know going into year two of a global pandemic is difficult. But rest assured I am here to support you to the best of my abilities.

Best,



Judy J. Wang, PT, DPT, PCS

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 are not 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 at the end of each treatment or evaluation 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 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 \$275. It will include a detailed report and prescribed exercises, though does not include any additional sessions.
- A travel fee of \$10 for every visit that is over 20 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 \$625 with all travel fees waived.
- 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.

SCHEDULING AND CANCELLATION POLICY

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 a social-media 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 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 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) 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 sitting independently? _____

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 Bumby

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				

Lil' Peanuts Physical Therapy

Phone (818) 937-3699

www.lilpeanutphysicaltherapy.com

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: _____