

COVID-19 Policy UPDATE (June 2023):

Dear Parents,

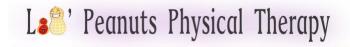
The past 3 years have been a challenging time for all of us. As restrictions are lifted and life returns to "normal," we want to reassure you that we still have your child and family's best interest at heart. Here are some recent updates to our proceedings that are designed to keep everyone safe:

- 1) For all indoor sessions with your child, please let me know in advance if you would like me to be masked and if anyone in the family is immunocompromised.
- 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 therapeutic materials.
- 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 two boosters 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 finding the right therapist for your child 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 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 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 \$300. 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 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 \$625 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 \$500. 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.

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.

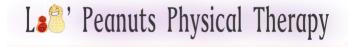
SPECIAL BILLING CIRCUMSTANCES

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

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
$\hfill\square$ 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 <i>Lil' Peanuts Physical Therapy</i> , <i>PC</i> , regardless of any insurance coverage.
SIGNATURE: DATE:
PRINT NAME:CHILD'S NAME:



Provider Name:
Title: Pediatrician

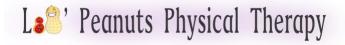
Phone (818) 937-3699 www.lilpeanutsphysicaltherapy.com

Phone Number:

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: Physical Therapist	Phone Number:
Provider Name:	
Title:	Phone Number:
Parent/Guardian's Signature:	Date:
Relationship to child:	
purposes. An important way to educate the gethrough sharing of information with other pare image of my child in therapy for education purposes specific permission from me is attained.	on campus presence for education and promotional general public on conditions treatable by Physical Therapy is ents in need. I understand that if LPPT decides to use an rposes, identifiable characteristics will be kept to a minimum d. I also understand that if I provide my signature below, representations of my child's therapy. However, I will
[] Only allowing LPPT to use videos/photogra [] Only showing the treatment room and/or tre [] LPPT can show any portion of treatment for	eatment techniques set up for my child.
Parent/Guardian's Signature:	Date:
participate in hands-on activities with patients physical therapy expert and my contributions	as a profession is by allowing graduate students to s. I understand that LPPT strives to be the go-to pediatric will directly contribute to the success of physical therapy as I will be notified if a student observer would like to participate
[] Please sign below if you DO NOT allow ar treatment with Lil' Peanuts PT.	ny observational visits from PT students as part of your
Parent/Guardian's Signature:	Date:
evaluation findings as part of a future case stresearch of certain pediatric conditions that m	below, I have agreed for LPPT to use any measurements or udy or research study that may contribute to scientific hay affect development. If LPPT choose to include my child 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 gua	ardian of	(hereinafter
"Patient"), with the birthdate of	, on behalf of myself and F	atient, have
authorized Lil' Peanuts Physical Therapy, F	P.C. ("LPPT") to provide Patient	t with certain agreed-
upon pediatric therapy services. I voluntaril	ly consent to the professional re	ecommendations,
evaluation, and/or treatment offered by LPF	•	•
agents have made any guaranty or promise		. ,
further acknowledge and agree that the suc		0 , .
Patient's and parents' and/or guardians' lev		
advice or suggestions given during therapy		
therapy, and for these reasons, LPPT cann	•	
treatment. I understand my right to know a	• •	
alternatives, and I acknowledge and unders		
questions of LPPT regarding any and all of	f 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

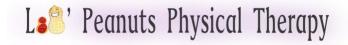


it supersedes any and all prior and/or contemporaneous agreements, understandings, and communications, whether oral or otherwise, regarding such matters. This General Waiver and Release shall be construed and interpreted in accordance with the internal laws of the State of California. Once this General 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.

declare that the foregoing is true and correct, aday of, 20	nd that it has been signed on this
Parent/Guardian's Signature:	
Printed Name:	
Address:	
Apt/Unit #:	
City, State, Zip Code:	



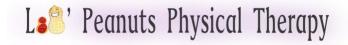
History Intake Form

Name of Child (legal):				:Gender:		
Pediatrician's Name (First and L						
How did you hear about us?						
Caregiver's Information #1:						
Name:						
Occupation/Title:		Work F	hone:			
Email:		Best w	ay to cor	ntact:		
Caregiver's Information #2:						
Name:						
Occupation/Title:		Work F	hone:			
Email:			ay to cor	ntact:		
Emergency Contacts (other than						
Name:	Relationship to	Child		Phone Number		
Referral Information:						
Name:	Relationship to	Child		Phone Number		
	•					
Ciblings						
Siblings: Name:	Gender	Age	Any rel	levant medical history		
Name.	Octidei	Age	Ally ICI	evant medical mistory		
Primary Language spoken at ho	me:					
Child's Dominant Language:						
Destinant Family Haalth History (physical devaluation of the series and the						
Pertinent Family Health History (physical, developmental, learning, etc):						
Why are you seeking this evalua	tion and physica	al therap	y?			
Has your child received any spe	cial services and	d/or thera	apeutic s	services in the past?		
			•	·		

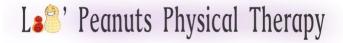


If Yes, Why?				
If Yes, please incl				
Provider Name:	Provider Phone Number:	Service Received:	Dates of Service:	Current Intervention:
Why were service	s discontinued?			
[] I would like mo		· ·	s evaluation and/or the	rapy?
	give details includir		adoption, surrogacy de	
Did a surrogate ca Any complications	ved via artificial repro arry the child? s during pregnancy? lain:		[] Yes []No [] Yes []No	
Medications taker	n during pregnancy:			
Born at:wee Born via: [] Vagin		C-section []B	reech (feet first) [] Ind	uced []Face-up
Birth Weight: If C-section: [] Pla	anned []Emergen	су		
If yes, please che [] Injury to mothe [] Bleeding [] High	gh blood pressure [ng: eeclampsia, ecla] Surgery [] Psy	ampsia, or toxemia []D vchological problems or []Fetal distress[]Feta	stress [] Illness
Was your child in	the NICU for any pe	eriod of time? WI	nat for?	
[] Feeding trouble [] Seizure (convu [] High fever [] I [] Chronic ear infe	our child have any on the control of	sive vomiting []0 oxygen []Breat Head banging [] e irritability []Co	roblems? Check all tha Constipation [] Bluenes thing trouble [] Yellow Slow weight gain [] Singenital defect [] Hear normality [] Other:	ss (cyanosis) jaundice tiffness





Treatments used for a	an infant comp	lications	s as indicated	abo	ve:			
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								montho
now old was the child	a when s/he wa	as wear	iea irom the b	ollie	or breast?			monus
DEVELOPMENTAL	HISTORY							
Developmental Miles								
What age did your ch	ild start tummy	/ time?_						
What age did your ch	ild start sitting	ındeper	ndently?					
What age did your ch	ild starting cra	wling or	n hands and k	nees	s?			
What age did your ch	ild start sleepii	ng on th	e belly?					_
What age did your ch								
What age did your ch	ild start walkin	g indep	endently?					
Any early feeding/slee Activity level as an inf	eping problem:	S:						
Activity level as all illi	iani. [] mign [JAVEIA	ige [] Low					
Any developmental co	oncerns?							
Any developmental of Any regression of skill	lls durina deve	lopmen	t?					
· ··· y · · · · g · · · · · · · · · · ·	are area and area are							_
At what age did you f	irst have conce	erns abo	out your child'	s fun	ctioning? _			
Please explain all of y	our concerns	that you	ı would like Ll	PPT	to address:			
Dana varia abild attan	al alass a a ma O M	/l O						
Does your child atten	d day care? v	vnere?				_		
Did/does your child spequipment?	pend significar	nt amou	nt of time (mo	re th	an 15 minut	es a d	lay) in	any sort of
[] Rock and Play	[]Bouncer	[] Sw	ing []] Jun	nper []	Walk	er	[]Bumbo
[] Car seat [] Sno			-	-				
MEDICAL HISTOR								
Please provide all me		nformat	· · · · · · · · · · · · · · · · · · ·				<u> </u>	
	Name		Phone Numl	ber	Date of las	st	Outo	come
Pediatrician								
Dentist								
ENT								
Ophthalmologist								
Developmental								
Optometrist								
Neurologist								
Psychologist/Neuro-								
Psych								



Phone (818) 937-3699

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Social Worker				
Psychiatrist				
Other:				
		nfections?		
Does your child have	a history of vision	n or hearing problems	?	
Please list any previous medication:	us medical condi	tions or illnesses that	required hospitaliza	ation, surgery, or
Please list the date a	nd type of surgeri	es or hospitalization _		
Have you been told o disability?	r do you feel like	your child may show o	characteristics of a	diagnosis or
Any additional comm				
Thank you so much finformation has been		ase sign here to ackno correct.	owledge that all of	the above
Parent signature:			Print name: _	
Child's full name:			Date:	