

www.pedisplayfamily.com  
info@pedisplay.com

PediPlay & MyPTIndy  
6239 South East Street Suite A  
Indianapolis, IN 46227-2088

## REGISTRATION FORM

(Please Print)



www.myptindy.com  
info@myptindy.com

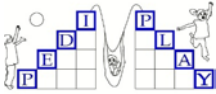
PATIENT INFORMATION	
Date: _____	
Patient's Name: Last/First/Middle: _____	Preferred Name: _____
Birth Date: MM/DD/YY _____	Age: _____ Sex: <b>M</b> <b>F</b> Social Security No: _____
Preferred Phone: _____	Alternative Phone: _____
Street Address: _____	City: _____
State: _____	Zip Code: _____ Email: _____
Primary Care Physician: _____	Diagnosis: _____
Physician Address: _____	
Physician Phone: _____ Physician Fax: _____	
Chose Clinic Because/Referred to Clinic By: _____ Relationship: (Circle One)	
Doctor Hospital Family Friend Close to Home/Work Therapist Other _____	
Other Family Members Seen Here: _____	

INSURANCE INFORMATION	
(Please give your insurance card & ID to the front office.)	
Person Responsible for Bill: _____	Birth Date MM/DD/YY: _____
Address, if different from above: _____	Home Phone: _____
Occupation: _____	Employer: _____ Employer Phone: _____
Employer Address: _____	
Is the patient covered by insurance: <b>YES</b> <b>NO</b> Subscriber's Name: _____ Subscriber's DOB: _____	
Subscribers SSN: _____ Group No: _____ Policy No: _____	
Co-Payment: \$ _____ Patient's Relationship to Subscriber (circle one): SELF SPOUSE CHILD OTHER	

BILLING OPTIONS	
(Please check one.)	
<input type="radio"/> I want PediPlay/MyPTIndy to bill my insurance:	
<input type="checkbox"/> Anthem <input type="checkbox"/> UnitedHealthCare <input type="checkbox"/> TriCare <input type="checkbox"/> Cigna <input type="checkbox"/> Sagamore <input type="checkbox"/> Medicaid Anthem HHW	
<input type="checkbox"/> Medicaid CMCS (Traditional) <input type="checkbox"/> Medicaid MHS Medicaid No: _____	
<input type="checkbox"/> Other _____	
<input type="radio"/> I want to Self-Pay, by self-paying I can receive a "payment at time of services are rendered discount".	

IN CASE OF EMERGENCY	
Name of local friend or relative (not living at same address): _____	
Relationship to Patient: _____	Home/Work Phone: _____ Mobile: _____

The above information is true to the best of my knowledge, I authorize my insurance benefits be paid directly to PediPlay or MyPTIndy (dba PediPlay). I understand that I am financially responsible for any balance. I also authorize PediPlay, MyPTIndy (dba PediPlay), or Insurance Company to release any information required to process my claims.	
Patient Signature: _____	Date: _____
If under 18, Parent/Guardian Signature: _____	Date: _____



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## PediPlay & MyPTIndy Patient Agreement

Our therapists seek to provide cost efficient therapeutic care for all our patients. To help us achieve this goal you, as the patient, agree to the following for the duration of your therapist-patient relationship with us.

Please realize that your insurance contract is between you and your insurance company. You are financially responsible for services rendered. However, as a courtesy, we will bill your insurance company, if you request us to do so. In these cases you agree to assign all payments to our office and authorize the collection of such insurance benefits by our office. Any co-payments are due at the time of service unless other arrangements are made in advance. To facilitate this process, you allow us time to release your medical records to your insurance company. You agree to pay any amounts not paid by your insurance company.

If we are not filing with your insurance company, payment must be made at the time of service.

If you default on paying your account and your account is assigned to an outside collection agency you will be charged the cost of collections. If your account is litigated you will be responsible for reasonable attorney fees, court fees and interest set forth by the court. Default on account will put therapy services on hold and may jeopardize your therapy time slot. Services will be restarted when a satisfactory payment plan is established and therapist caseload allows.

Any checks returned for non-payment are subject to fees set forth by state and local laws. After the second return, repayment must be made by cash or money order.

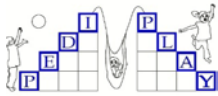
I have read and agree to the "Patient Agreement".

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
If under 18, Signature of Parent/Guardian

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Date



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## Patient Allergy & Medical Information

Patient Name: \_\_\_\_\_

Please list any known allergies to drugs, latex, band aids, inhalants, foods, environmental triggers or animals.

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Please list any food sensitivities or contact irritants.

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☐ No Known Allergies

**Please list any known medical diagnosis, conditions, or restrictions.**

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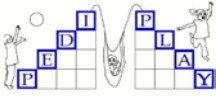
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Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

If under 18, Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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## **PediPlay & MyPTIndy Clinic Attendance Policy**

Patients and providers are encouraged to be on time and keep all scheduled appointments. However, special circumstances may arise and appointments may be adjusted. The following attendance policy agreement is to ensure smooth delivery of services between the patient and provider.

### **Late Arrival:**

Call the clinic immediately if you will be more than 10 minutes late to your appointment.

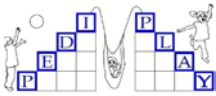
- It will be at your provider's discretion and dependent on the availability of the clinic if you will be able to keep your appointment.
- Any session unable to be accommodated around your scheduled day and time will be rescheduled in the same week or you may be charged a \$25 "No-Show" fee.
- All subsequent "No-Show" sessions you may be charged the full therapy billing rate.

### **Cancellations:**

- Call the PediPlay & MyPTIndy office as soon as you know you will be unable to keep a scheduled appointment date and time. Provide the day, time and reason you will be unable to keep your appointment. Leave a message on the answering machine if outside of clinic operating hours.
- Multiple no-call/no-show appointments keep the clinic from utilizing a time slot for another patient. Two no-call/no-shows may cancel an ongoing time slot.
- Please make an effort on your part to reschedule as we want you to benefit from your therapy program.

### **Inclement Weather:**

- PediPlay & MyPTIndy clinic will be open unless emergency conditions restrict travel in which case office staff will contact you to cancel your appointment due to the clinic closing.
- Patient may cancel sessions without penalty on inclement weather days with as much notice as possible to the clinic.



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The Board of Health considers the following signs to indicate communicable disease/illness:

- Vomiting
- Diarrhea
- Rash/Swelling
- Fever Over 100 Degrees
- Sore Throat
- Red or Running Eyes

You must be symptom free for 24 hours before returning to therapy.

If you have any questions or need further clarification, please contact our office at (317) 791-9031.

**I have read and understand this Clinic Attendance Policy.**

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Patient Signature

Date

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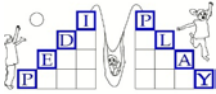
Provider Signature

Date

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If under 18, Signature of Parent/Guardian

Date



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## Lending Library Policies

### Statement of Mission

We are pleased to offer our patients the opportunity to borrow resource materials that are pertinent to the continuing of your education and development. We hope you will utilize these resources as applicable to you and your family.

### Policies

We appreciate your complying with the following policies. This will help us to serve your needs and the needs of other patients.

1. All materials (except specially designated books, videotaped, DVDs, and CDs) may be borrowed for a period of one week.
2. Materials may be renewed for an additional one-week period if there are no pending requests for the item.
3. Materials may be borrowed by patients currently receiving services at this clinic.
4. Borrowers are responsible for returning materials in a timely manner and in good condition. Damaged materials or materials not returned within seven days of their due date or patient discharge will be charged to the borrowers account according to the posted list price.
5. Designated materials are available for purchase through the clinic office. We will make every effort to provide patients with purchasing information on other materials as desired.

**I have read and I understand the above regulations and agree to abide by all of them. I understand that any lost or damaged materials will be charged to my account.**

Signature\_\_\_\_\_

Date\_\_\_\_\_



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## MyPTIndy Photo Release

Patient Name (print): \_\_\_\_\_

Patient Address: \_\_\_\_\_

MyPTIndy Professional (print name/title): \_\_\_\_\_

I may be photographed for therapy documentation: YES NO

I may be photographed for teaching purposes: YES NO

I may be videotaped for teaching purposes: YES NO

I may be photographed for press release: YES NO

I may be photographed for MyPTIndy promotional material: YES NO

My photograph may be posted on the MyPTIndy website

without face showing: YES NO with face showing: YES NO

My photograph may be posted on MyPTIndy Facebook

without face showing: YES NO with face showing: YES NO

My first name may be used with photo/video release: YES NO

Comments:

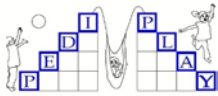
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Patient Signature \_\_\_\_\_ Printed Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Date \_\_\_\_\_



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## PediPlay Photo Release

Patient Name (print): \_\_\_\_\_

Patient Address: \_\_\_\_\_

PediPlay Professional (print name/title): \_\_\_\_\_

My child may be photographed for therapy documentation: YES NO

My child may be photographed for teaching purposes: YES NO

My child may be videotaped for teaching purposes: YES NO

My child may be photographed for press release: YES NO

My child may be photographed for PediPlay promotional material: YES NO

My child's photograph may be posted on the PediPlay website

without face showing: YES NO with face showing: YES NO

My child's photograph may be posted on PediPlay Facebook

without face showing: YES NO with face showing: YES NO

My child's first name may be used with photo/video release: YES NO

Comments:

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Parent/Guardian Printed Name

Phone Number

If under 18, Parent/Guardian Signature

Date





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## Acknowledgement of Receipt of Notice of Privacy Practices

PediPlay & MyPTIndy  
6239 South East Street, Suite A, Indianapolis, IN 46227

This is to acknowledge my receipt of PediPlay & MyPTIndy's Notice of Privacy Practices effective date which is October 1, 2017 an effective for the patient on the date stated below.

\_\_\_\_\_  
Date of Patient's or Personal Representative's  
Signature

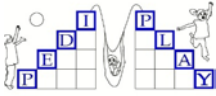
\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's Address

\_\_\_\_\_  
Name of Personal Representative  
(If applicable)

\_\_\_\_\_  
Description of Representative's Authority to Act for the  
Patient (If applicable)



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## Use of Texting

### PLEASE READ CAREFULLY BEFORE SIGNING

I hereby authorize PediPlay & MyPTIndy providers and staff to contact me by texting for the purposes of scheduling appointments. Protected Health Information will not be shared via the texts.

This consent is effective from the date of my signature. I may revoke my consent in writing to PediPlay & MyPTIndy at any time.

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Patient Name (Printed)

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Patient Signature

Date

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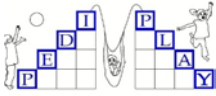
If under 18, Parent/Guardian Signature

Date

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Witness Signature

Date



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I, \_\_\_\_\_, the authorize students under PediPlay & MyPTIndy therapist(s)  
supervision

- ☐ to observe my session
- ☐ to work in my session

I may revoke this consent at any time in writing to the PediPlay & MyPTIndy office manager or director.

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Patient Signature

Date

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I, \_\_\_\_\_, the parent/guardian of \_\_\_\_\_  
hereby authorize PediPlay & MyPTIndy to release and receive any necessary information regarding the  
treatment of my child to the following individual(s). The following individual(s) are also authorized to transport  
my child to and/or from therapy services.

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

☐ Photo or ID on File

☐ Photo or ID *Declined*

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

☐ Photo or ID on File

☐ Photo or ID *Declined*

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

☐ Photo or ID on File

☐ Photo or ID *Declined*

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

☐ Photo or ID on File

☐ Photo or ID *Declined*

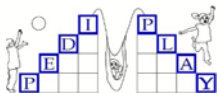
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Patient Signature

Date

☐ Patient Photo or ID on File

☐ Patient Photo or ID *Declined*



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## Release for Appointment Reminders

I, \_\_\_\_\_ (print), hereby authorize PediPlay & MyPTIndy to send me an appointment reminder via e-mail or text message using the following information.

*Email reminders may contain patient or clinic information such as,  
but not limited to, patient first name and clinic location.*

Patient Contact Information:

*(Please print clearly and legibly)*

Email:

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Cell Phone:

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Patient Name (Print):

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Signature:

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Date:

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