MAST CLINIC, Inc.

Helping Children to Be their Best

Jacqueline Mast, PT,MSEd,FAACPDM
kid whisperer
physical therapist
expert: infant/toddler behavior & development
……

980 Forest Ave #100, Portland, ME 04103
phone 207 689 6278 **fax** 207 747 4107
info@mastclinic.com

Patient Name_____Date of Birth_____Diagnosis_____

Parents' Names_____ _____

Address_____City_____State_____ Zip_____

Phone _____ _____ Email*_____
**reports and some correspondence will be emailed for your convenience*

Physician_____

Parents' Employer_____Address_____

Employer_____Address_____

Insurance Company*_____Subscriber Name_____
**copays due at time of service. Please bring your child's insurance card to the first visit.*

Certificate #_____Group#_____

#1 - Authorization to treat and release information about treatment: *I give permission for my child to receive physical therapy evaluation and treatment at Mast Clinic. I authorize all providers of service to release such information as requested by insurance companies or other third party payors for all current and future claims.* _____ (**Please initial)**

#2 - Assignment of insurance benefits and accept responsibility for all out of pocket responsibilities: *I request payment of any and all benefits directly to Mast Clinic, Inc. I understand that benefits are subject to the terms, conditions, exclusions, and limitations of my plan documents, including my certificate of coverage or summary plan description. I specifically authorize and direct that any applicable insurance benefits be paid directly to Mast Clinic, Inc. for credit to my account. I am responsible for payment of all services to Mast Clinic, Inc. for charges not covered by this assignment. Co-pay will be paid at time of service. All invoices over 30 days will be charged 1.5% interest (18% APR). I understand that I am responsible for all reasonable legal and collection costs.* _____**(Please initial)**

#3 - Responsibility to provide updates and appointment cancellations: I *understand it is my responsibility to inform Mast Clinic when my child changes primary care physicians and/or has changes in insurance coverage; failure to do so will result in insurance denials or reduced benefits and my full responsibility for all unpaid balances.*
I agree to give at least 24 hours notice of cancellation of appointments (with the exception of child's illness or a snow day). Mast Clinic reserves the right to charge $200 for missed appointments. Failure to give 24 hours notice on 3 occasions will cause my child to lose the privilege of receiving physical therapy services at Mast Clinic. _____ **(Please initial)**

Signature of Parent_____ Date _____

……

For office use: Initial visit date: Diagnosis: Referral:

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Patient Name_____ **Date of Birth**_____

Chief Complaint (please state the reason for bringing your child to Mast Clinic):

_____

When did the problem begin?_____

Do you think there is anything that brought this problem on?_____

_____

Is there anything that makes the problem worse?_____

_____

Is there anything that makes the problem better?_____

_____

Does anyone in your family have the same problem?_____

What are your child's
strengths?_____

_____

What do you think our services can do for your
child?_____

_____

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Patient Name_____ Date of Birth_____

What is your child's diagnosis?_____

When was the diagnosis first made?_____ By whom?_____

Does your child take medications? Please list:_____

_____

Describe your concerns for your child_____

_____

Do both parents agree concerning the child's problem?_____

BIRTH INFORMATION

Were there problems during pregnancy?_____

Premature?_____ If so, how early?_____

Weight_____ Length of hospital stay_____

Complications_____

OTHER PROBLEMS

During infancy_____

Current other problems_____

DEVELOPMENTAL INFORMATION

At what age did your child reach the following milestones?
Rolling __months Sitting __months Crawling/Scooting ___months Walking __months

Who does your child like to play with?_____

What are your child's *favorite toys*?_____

What behavior patterns does your child have that you are concerned about?

_____

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Does your child live at home?_____Do you live in (circle one)city, town, country
Circle one: Apartment, condo, house, mobile home
Who lives with the child? (Please include names and ages of all people)

_____

_____

Are there things that are hard for your child to do?_____

_____

What do you hope your child will learn to do?_____

_____

What is your child's sleep pattern?

Naps_____Night_____

What does you child like to eat?_____

_____

What does your child refuse to eat?_____

_____

Are there other concerns you have about your child?_____

_____

_____

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