Children's Therapy WORKS

Dear Family,

Thank you for contacting us about providing a therapy evaluation for your child. Please find the enclosed information packet. After you have filled this out, please return it to our office so that we may begin processing your application.

If we bill insurance for you, we will assist you by verifying your benefits with your insurance company. We also suggest you check with your insurance company to determine whether the Therapy your child needs is a covered service under your policy.

Once your application is complete, a Therapist will contact you to set an appointment. Should you have any questions in the meantime, please do not hesitate to contact us.

We look forward to getting to know your family!

Best Regards,

The Staff of Children's Therapy Works

63 Sarasota Center Blvd, Suite 101, Sarasota, FL 34240
Tel. 941-379-3725, Fax. 941-377-1131, www.ctwsrq.com

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Patient Information

Patient's Name: _____ Date of Birth: _____

Address: _____
Number, Street

_____
City, State, Zip

Email address: _____ Home Phone: ( ) _____

Mother's Name: _____ Mother's Cell Phone: ( ) _____

Father's Name: _____ Father's Cell Phone: ( ) _____

Physician: _____ Physician's Phone: ( ) _____

Insurance Information

Insured's Name: _____ Insured's Employer: _____

Primary Insurance Co: _____ Insurance Phone: _____

Insurance ID #: _____ Group #: _____

Secondary Insurance Co: _____ Insurance Phone: _____

Insurance ID #: _____ Group #: _____

Medicaid Card #: _____

Client of CMS? YES / NO Early Steps Program? YES / NO

Authorized (Insured) Person's Signature

I hereby authorize the release of medical or other information necessary to process insurance claims. I authorize payment of medical benefits to Children's Therapy Works.

_____ Date: _____
Insured's Signature

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Patient Background Information

Patient's Name: _____ Birth Order: _____

Diagnosis: _____ Birth Weight: _____

Circle birth term: PREMATURE FULL TERM POSTMATURE

Describe if necessary: _____

Apgar Score at 1/5 mins: _____

Circle birth type: FORCEPS VACUUM C-SECTION

Any complications during pregnancy (illness / infections / stress)? YES / NO

Describe: _____

Any complications during labor and delivery? YES / NO

Describe: _____

Difficulty nursing and/or bottle feeding? YES / NO History of Reflux? YES / NO

Managing a varied, age-appropriate diet? YES / NO

Developmental Milestones

Please note approximate age at which he/she did the following:

Sat up: _____ Belly crawled: _____ Crawled: _____

Cruised: _____ Walked: _____ First Words: _____ Talked: _____

Undressed self: _____ Dressed self: _____ Zippers & buttons: _____ Tied shoes: _____

Started school: _____ Toilet trained (bladder): _____ (bowel): _____

Preferred hand? LEFT / RIGHT --> Age established: _____

Ear infections? YES / NO --> How many, at what ages? _____

Allergies? YES / NO --> Describe: _____

Injuries/hospitalizations? YES / NO --> Describe: _____

Seizures? YES / NO --> Describe: _____

Most recent eye exam date: _____ Hearing exam date: _____

Medications? YES / NO List: _____

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PARENT'S CONCERN LIST

Name: _____

Please indicate areas that are of concern for you or your child.

- ☐ Mobility
- ☐ Feeding
- ☐ Fine Motor Skills
- ☐ Gross Motor Skills
- ☐ Speech
- ☐ Developmental Progres
- ☐ Attention
- ☐ Play Skills
- ☐ Self-esteem
- ☐ Peer interaction
- ☐ Family adjustment
- ☐ Learning rate

Please indicate any other areas of concern below:

1. _____
2. _____
3. _____

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SENSORY PROCESSING HISTORY

Name: _____

Please mark with a check (✓) those items that currently describe your child. Please mark with an asterisk (*) those items that previously described your child. Feel free to add items that you think are related so that they can be discussed with the therapist.

TACTILE

- ☐ dislikes having teeth brushed
- ☐ dislikes dental visits
- ☐ dislikes wearing socks/shoes
- ☐ dislikes having face washed
- ☐ dislikes hair combing
- ☐ dislikes feeling of new clothes
- ☐ wants tags in clothes cut out
- ☐ dislikes having feet touched
- ☐ dislikes having hand held
- ☐ dislikes seams in clothing/socks
- ☐ has strong clothing preferences
- ☐ dislikes elastic in sleeves/waist
- ☐ dislikes wearing shorts/bathing suit
- ☐ dislikes playing with messy materials
- ☐ seems over-sensitive to unexpected touch
- ☐ avoids physical affection unless self-initiated
- ☐ constantly seeks to touch people or things
- ☐ needs to hold objects in hand
- ☐ excessively mouth objects or chews clothes
- ☐ bangs head intentionally
- ☐ overreact to getting hurt
- ☐ under-react to getting hurt
- ☐ becomes impatient/disruptive standing in line
- ☐ seem excessively ticklish
- ☐ frequently bumps/pushes/fights with others
- ☐ dislikes long sleeves, high necklines
- ☐ over or under dress for temperature
- ☐ dislikes baths or showers
- ☐ other (describe) _____

_____

VISUAL

- ☐ has a diagnosed visual problem
- ☐ appears sensitive to light
- ☐ excessively blinks, squints, rubs eyes
- ☐ short attention for visual activities
- ☐ avoids eye contact
- ☐ loses place while reading or copying
- ☐ gets easily distracted by vis. stimulation

Date of last vision exam: _____

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SENSORY PROCESSING HISTORY (cont.)

OLAFACTORY AND GUSTATORY

- ☐ unaware of flavors, taste
- ☐ eat a limited variety of foods
- ☐ explores objects first by smell
- ☐ difficulty recognizing odors
- ☐ unaware of noxious odors
- ☐ over-sensitive to taste, flavors
- ☐ over-sensitive to temperature
- ☐ over-sensitive to smells
- ☐ reacts negatively to certain foods
- ☐ dislikes carbonated beverages

PROPRIOCEPTIVE

- ☐ loves to be held tightly
- ☐ breaks toys, squeezes objects
- ☐ pushes too hard on objects
- ☐ seeks pressure on his body
- ☐ crashes into things (on purpose)

AUDITORY (sound)

- ☐ over-sensitive to loud sounds
- ☐ likes to make loud sounds
- ☐ misses sounds, difficulty following directions
- ☐ diagnosed speech problem
- ☐ diagnosed hearing problem

VESTIBULAR (movement)

- ☐ experiences car sickness
- ☐ reacts fearfully when moved
- ☐ dislikes merry-go-rounds, tire swings
- ☐ seeks excessive movement
- ☐ avoids balance activities
- ☐ clumsy/falls down/runs into things
- ☐ has difficulty sitting still

REGULATORY

- ☐ easily distracted
- ☐ difficulty with bowel/bladder training
- ☐ difficulty with sleep patterns
- ☐ problems with appetite control
- ☐ short attention in group activity
- ☐ dislikes changes in routine
- ☐ unusually high energy level
- ☐ unusually low energy level

MUSCLE TONE

- ☐ poor posture
- ☐ poor strength and endurance
- ☐ tires easily
- ☐ often props head in hand at table

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AUDITORY SENSITIVITY CHECKLIST

Name: _____

Observation of the following items in a person may indicate auditory (hyperacute hearing) problems.

MEDICALLY

- ☐ has a history of hearing loss
- ☐ has a history of ear infections

ATTENTIVENESS

- ☐ does not pay attention (listen) to instruction 50% or more of the time
- ☐ does not listen carefully to directions, often necessary to repeat instructions
- ☐ says "Huh?" and "What?" at least five or more times per day
- ☐ cannot attend to auditory stimuli for more than a few seconds
- ☐ has a short attention span of : ____ 0 - 2 ____ 2 - 5 ____ 5 - 15 ____ 15 - 30 minutes
- ☐ daydreams, attention drifts, not with it at times
- ☐ is easily distracted by background sound(s)

PHYSICALLY

- ☐ startles easily in response to sound stimulus
- ☐ covers ears when sounds are objectionable
- ☐ responds to various sounds with wide open eyes and flared nostrils

ACADEMICALLY

- ☐ has difficulty with phonics
- ☐ experiences problems with sound discrimination
- ☐ forgets what is said in a few minutes
- ☐ does not remember simple routine things from day-to-day
- ☐ displays problems recalling what was heard last week, month, year
- ☐ has difficulty recalling a sequence that has been heard
- ☐ experiences difficulty following auditory directions
- ☐ frequently misunderstands what is said
- ☐ does not comprehend many words, poor verbal concepts for age/grade

AUDITORY SENSITIVITY CHECKLIST (cont.)

- ☐ learns poorly through verbal instruction
- ☐ has a language problem (morphology, syntax, vocabulary, phonology)
- ☐ has an articulation (phonology) problem
- ☐ cannot always relate what is heard to what is seen
- ☐ lacks motivation to learn
- ☐ displays slow or delayed response to verbal stimuli
- ☐ demonstrates below average performance in one or more academic areas

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CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____ to release information from the records of _____.

The information is to be released to Children's Therapy Works for the purpose of developing a Therapeutic Program for the above named client. The information to be released is marked below.

- ☐ Medical History
- ☐ Physical Therapy Evaluation, assessment and program plan
- ☐ Occupational Therapy Evaluation, assessment and program plan
- ☐ Speech Therapy Evaluation, assessment and program plan
- ☐ Classroom Individual Educational Plan (I.E.P.)
- ☐ Other: _____

_____ Date: _____

Signature

_____

Name of Parent or Guardian

Please send the indicated material to:-

Children's Therapy Works
63 Sarasota Center Blvd, Suite 101
Sarasota, FL 34240

Children's Therapy WORKS

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CHILDREN'S THERAPY WORKS FINANCIAL POLICY

Name: _____

Thank you for choosing us as your health care provider. We are committed to your child's therapeutic needs. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete our "Information and Insurance" form before seeing the therapist.

FULL PAYMENT IS DUE AT TIME OF SERVICE

WE ACCEPT CASH, CHECKS AND CREDIT CARD

WE WILL BILL MEDICAID, EARLY STEPS AND SOME INSURANCE COMPANIES WITH PRIOR APPROVAL

WE OFFER EXTENDED PAYMENT PLANS WITH PRIOR APPROVAL

Regarding Insurance
We may accept assignment of insurance benefits after your second visit. However, we do require anticipated deductible and co-pay of the bill to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information, a copy of your insurance card, and an original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits, we require that you be preapproved on our extended payment plan. If your insurance company has not paid your account in full within 60 days, the balance will be automatically billed to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance.

Regarding Insurance Plans where we are a participating provider -- all co-pays and deductibles are due at time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

Missed Appointments
Unless canceled at least 24 hours in advance, our policy is to charge you for the missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments. Sudden onset of illness may be excused by your therapist.

I have read, understood and agree to the above Financial Policy.

_____ Date: _____

Signature

_____

Printed Name

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NOTICE OF PRIVACY PRACTICES

Our commitment at Children's Therapy Works is to serve our clients with professionalism and caring. We want to protect the privacy and security of all Protected Health Information.

During the course of serving your interests, it may be necessary to share information with other health care providers or business associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a specialized study (such as a swallow study)
- For payment purposes, we may use the services of a billing service and/or billing clearing house
- During health care operations, we may need a specialized evaluation and/or consult services

At Children's Therapy Works, we are committed to obeying all Federal, State and Local laws and regulations regarding privacy practices. If any other uses or disclosures than the ones listed above are required, infromation will only be released with your written authorization (parent, or legal guardian of a minor). This written authorization may be revoked at any time by the individual (parent, or legal guardian of a minor) as provided by law.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer **Ian Harding** at **941-379-3725**.

I have read and understand the above Notice of Privacy Practices.

_____ Date: _____

Signature

_____

Name of Parent or Guardian

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CONSENT OF DISCLOSURE

I hereby give consent to Children's Therapy Works and all health care providers furnishing care within Children's Therapy Works' facilities, to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

You can cancel this consent at any time. Your cancellation must be in writing, signed by you or on the behalf of a minor by parent or legal guardian, and delivered to the address at the top of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by calling our Privacy Officer, **Ian Harding** at **941-379-3725**.

_____ Date: _____

Signature

_____

Name of Parent or Guardian

CANCELLATION

I hereby void the consent given above.

_____ Date: _____

Signature

_____

Name of Parent or Guardian