Therapedia #:_____

Therapedia™, LLC
Exceptional therapy for children.

PATIENT INFORMATION

BACKGROUND
Questionnaires assist therapists to gather valuable information about a child's history and functioning in the home and community environments. This information is used to interpret test results and observations during evaluation. Please fill out the questionnaire as completely as possible. Additional written comments are welcome. If you have questions about any of the questionnaire items, contact Therapedia and your question will be directed to the appropriate therapist. Thank you.

Child's name_____ Date of Birth _____

Number of children in family and ages_____

Who lives at home?_____

School_____ Teacher_____ Grade_____

Reason for seeking evaluation and/or therapy_____

_____

Has your child received previous evaluation and/or therapy?_____ If so, where and describe_____

_____

How does your child get around in their environment (crawls, walks, w/c etc) daf_____
Does your child have any adaptive equipment/items used to assist your child?_____

_____

When did you first notice your child's difficulties, and how were they apparent to you?_____

_____

_____

ELECTRONIC USE HISTORY:

What devices does your child have access to: _____TV _____Tablet _____Phone _____Other

How much time does your child spend on electronic devices: _____TV _____Tablet/computer _____Phone

Does your child use an electronic device: _____at bedtime _____at mealtime _____Other

DEVELOPMENTAL HISTORY
Prenatal History

Mother's age at birth of child _____ Father's age at birth of child_____
Were there any complications during pregnancy such as illness, Rh negative, German measles? If yes, please describe_____

_____

Did mother take any medication during pregnancy?_____ If yes, please list_____

_____

Therapedia #:_____

Birth History

( ) Full term ( ) Premature	If premature, give: Month_____ Weight_____	( ) Vaginal birth ( ) Cesarean birth
Was labor: ( ) prolonged ( ) short ( ) within normal range APGAR score, if known_____	Were forceps used?_____ Medication during delivery: _____ _____ Time in NICU?_____ Time on ventilator/oxygen_____ _____	Were there other complications such as: ( ) breathing difficulty ( ) jaundice ( ) tube fed ( ) feeding difficulty ( ) incubation ( ) transfusion ( ) congenital defects

Was your child breast-fed? _____ If yes, how many weeks/months?_____

Did your child have difficulty breast feeding?_____ If yes, explain_____

Did your child have difficulty using the bottle?_____ If yes, explain_____

Medical History

Has your child had any of the following? If yes, give dates.

Meningitis_____ High temperatures _____ Seizures_____

Ear infections_____ _____

Allergies: ( ) latex ( )food - specify_____ ( ) other – specify_____

Physical Injuries (describe and date)_____

_____

Surgeries/Medical Procedures (describe and date)_____

_____

Hospitalizations (describe and date)_____

_____

Medical diagnoses such as diabetes, epilepsy, heart trouble, autism, ADHD_____

Is your child currently on medication?_____ Please list and state for which problem_____

_____

Is your child currently on supplements, holistic care, over the counter medications, etc?_____

_____

Has your child had a hearing test?_____ Results_____

Does your child wear glasses?_____ Has he/she had an eye exam?_____ Results_____

Does your child wet the bed after 3 years of age?_____

Does your child have trouble learning urinary control?_____

Does your child have trouble learning bowel control?_____

Other medical history_____

_____

Therapedia #_____

Developmental History

Give ages as near as possible:

Rolled over_____; walked_____; sat alone_____;

crawled on hands and knees_____; crawled- other type (age/describe)_____/_____;

talked (simple words)_____; talked (sentences)_____

Does your child use verbal communication to express wants/needs? _____sometimes _____always _____often _____rarely _____never

Does your child seek out others in order to initiate communication or interaction? _____sometimes _____always _____often _____rarely _____never

Does your child become frustrated when speech is difficult to understand or when unable to communicate? _____sometimes _____always _____often _____rarely _____never

Check behaviors which describe your child as an infant:

( ) cried a lot, fussy, irritable	( ) like being held	( ) tense when held
( ) good, non-demanding	( ) drooled excessively	( ) very active
( ) alert	( ) resisted being held	( ) good sleep patterns
( ) quiet or passive	( ) floppy when held	( ) irregular sleep patterns

School Performance

Please describe your child's:

Relationship with teacher_____

_____

Relationship with classmates_____

_____

Areas of academic difficulty_____

_____

Areas of most success or enjoyment_____

_____

Does your child require adaptation in the classroom (describe)?_____

_____

Parental concern

Please use the following space to share with us any other concerns/information that you feel we should know.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Parent Date

Therapedia #_____

Therapedia™, LLC
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REGISTRATION FORM

Prescribing Physician_____

Patient/Child Information:

Child's Name_____ Child's Date of Birth____/_____/_____
Address_____
City_____ State_____ Zip_____ Sex _____male _____female
Primary Contact Phone #_____ email _____

Parent/Responsible Party

( )lives with child **Parent Name**_____ Address: ( )same as child _____ _____ Phone:_____ H W C DL#:_____ Date of Birth:_____	( )lives with child **Parent Name**_____ Address: ( )same as child _____ _____ Phone:_____ H W C DL#:_____ Date of Birth:_____

Emergency Contact *(other than parent)*

_____
_____
_____

Whom may we thank for the referral?

_____
_____
_____

AUTHORIZATION FOR TREATMENT

I authorize treatment of my child listed above and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct unless notification is received within 30 days of statement date.

_____ _____
Signature of Responsible Party Date

RELEASE AND AUTHORIZATION TO PAY THERAPEDIA, LLC

I understand that Therapedia, LLC may need to use and disclose information about my child's health or medical concerns for the purpose of arranging, conducting, or referring their treatment; for obtaining payment for services, and for the purpose of operating the practice. I consent to the use of my child's information to any insurance company, agency, adjuster, or attorney for the purpose of treatment, payment and health care operations.

_____ _____
Signature of Responsible Party Date

Therapedia #:_____

Therapedia™ LLC
Exceptional therapy for children.
phone (817)562-3111 fax (817)562-3114

CONSENT FOR RELEASE OF INFORMATION

I, _____, am the *(circle one)* parent / surrogate parent /

legal guardian of_____, date of birth_____
(Child's name)

and I hereby authorize **Therapedia, LLC** and the following named individuals/institutions/professionals along with the insurance company to RECIPROCALLY RELEASE AND DISCLOSE INFORMATION IN WRITTEN AND VERBAL FORM, DISCUSS MY CHILD, AND FORWARD CURRENT EVALUATIONS, PROGRESS REPORTS, AND NOTES BETWEEN:

Pediatrician:_____ Other Physician *(specify)*_____

Therapist (OT/PT/ST)_____ Teacher/Educator:_____

Psychologist:_____ Hospital: _____

Other *(specify):*_____

_____

I also give permission for Therapedia to photograph/video my child, for the following purposes:

Purpose	**I consent (parent initials to consent)**	**I decline (parent initials to decline)**
Still photographs for:		
Evaluation and treatment purposes		
Education purposes		
Display on website, promotional materials, or social media		
Video Tape for:		
Evaluation and treatment purposes		
Education purposes		
Display on website, promotional materials, or social media		

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

_____ ____/____/____ _____
(Parent/Guardian signature and date) (witness)

Therapedia™, LLC
Exceptional therapy for children.

FINANCIAL POLICIES

Thank you for choosing Therapedia, LLC. Because healthcare benefits and coverage options have become increasingly complex, we have developed these policies to help you better understand your responsibilities and eliminate any unnecessary confusion. Please carefully read through the following financial information.

UPDATES: Please advise us any time there is any change to your address, telephone or other contact information. If your insurance changes or discontinues mid-treatment, including receiving new insurance cards, please provide us this information immediately so there is no delay in billing.

INSURANCE COVERAGE: As a service to our patients, Therapedia, LLC is more than happy to directly bill your primary insurance for services rendered, but it is our policy that the *patient* is ultimately responsible for payment of the services received from Therapedia, LLC. We do not bill secondary insurance, but upon request will provide you with a receipt that you may submit. Furthermore, the *patient* is responsible for understanding their insurance coverage in relation to covered services.

We make every attempt to verify your current insurance coverage. Verification of benefits is NOT a guarantee of payment. If we contact your insurance carrier regarding benefits or authorization on your behalf, we are not responsible for inaccurate information provided to us by your carrier. The information about your plan that we relay to you is in good faith. Please remember that any changes made to your insurance policy and the time of year billing is submitted may affect coverage and reimbursement rates.

Deductible and co-payments are part of your contractual agreement with your insurance company, and it is our responsibility as participating providers to collect those fees. **Deductible and co-payments are due at each visit**. A refund is issued when an overpayment has been identified. If you feel a refund is due, please contact our office.

NO INSURANCE/CASH RATE: We believe that no one should be denied therapy services secondary to lack of insurance coverage. Our clinic offers a discounted cash rate to those who do not have insurance coverage or elect to not use insurance benefits. Payment will be required at the time of service or before *unless arrangements are made in advance*. Please inquire about our current cash pay rate if it is applicable to your situation.

PAYMENTS: Therapedia, LLC accepts payment in the form of cash, checks, or credit card (VISA, MC, or Discover). Any unpaid balances will be billed to you. A $30 NSF (non-sufficient funds) fee will be charged for any checks returned to our office because of insufficient funds. If we receive a returned check, we will notify the patient or responsible party immediately and request that a cash payment be brought to our office within 24 hours to replace the amount of the full amount of the check.

COLLECTIONS: If your account is more than 90 days past due, without an established payment plan on file, we will begin immediate collection actions. Your account will be assessed a 35% late fee. If you do not pay your bill following our internal collection efforts, your account will be sent to an outside collection agency. If your account is sent to a collection agency, you will need to contact them directly to settle your balances.

MEDICAID ONLY: Children with an active Medicaid policy can submit that information to Therapedia. We will request authorizations and submit claims to our contracted agencies. Your child's information will be submitted to Medicaid as required to secure payment.
_____ (Initial) **I understand that, in the opinion of Therapedia, LLC, the services I have requested for my child may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for their care. I understand that I am responsible for payment of the services requested and received if these services are determined by Medicaid not to be reasonable and medically necessary for my child's care.**

FINANCIAL AGREEMENT: (Initial One)

_____ I elect to have Therapedia, LLC bill insurance for my child's visits. I hereby authorize my insurance benefits to be paid directly to Therapedia, LLC and I am financially responsible for non-covered services.

OR:
_____ I will not be using insurance benefits and elect to pay for services at the cash rate.

I have read and agree to the above information.

Patient name: _____

_____ _____
Signature of Responsible Party (must be over 18 years old) Date

Therapedia,LLC

Exceptional therapy for children.

ATTENDANCE POLICY

Your therapy team at Therapedia,LLC is committed to helping your child meet their therapy goals. In order to achieve goals and make steady progress, consistent attendance is very important. Consistent attendance at the prescribed frequency results in greater success and shorter overall duration of therapy.

Purpose of the attendance policy: To ensure improved outcomes and accommodate scheduling availability for clients that are committed to attending.

Please note: Occupational, physical and speech therapy are considered medical services. Poor attendance can result in your services no longer being covered by insurance.

Attendance: Attendance rates of at least 75% are required in order to maintain a recurring appointment. If attendance rates fall below 75% over a 3 month period, your recurring appointment will be removed and scheduling will be available only on a week to week basis. In order to resume recurrent appointment scheduling, attendance of greater than 75% over the following three months will be required.

Cancellations: Prior notice is necessary. Please provide at least 24 hours notice if your child will not be able to attend. Call 817-562-3111(Keller Clinic) or 940-654-4011(Justin Clinic) as soon as possible. Leave a message and provide a reason for the cancellation.

Missed appointments / No shows: A fee of $50 will be charged to you for any appointment that is missed without cancellation, including appointments for evaluations. If the missed appointment is rescheduled, the fee will be applied to the rescheduled appointment once it has been attended.

Vacations: We appreciate a 2 week notice of vacation plans. Families who are planning to be absent for more than 2 weeks will be removed from the schedule and placed on their therapist's waiting list.

Late arrivals: If you will be more than 10 minutes late for an appointment, please call to verify that your therapist can still see you. If you are 15 or more minutes late for an appointment, your appointment may be canceled and considered as a missed appointment/no show. A consistent pattern of late arrivals may result in a discontinuation of services.

I have read and understand the Therapedia,LLC attendance policy.

_____ _____

Signature Date

Therapedia, LLC
Exceptional therapy for children.

POLICY STATEMENT

_____ *Initial*

ILLNESS

If your child is ill, please cancel your appointment. Your child will not receive the full benefit of the therapy session if they are too ill to fully participate. Additionally, they may infect other children. **Your child should be free of symptoms, contagion, fever or vomiting for 24 hours before returning to therapy.** We will follow the CDC recommendations regarding restrictions to prevent the spread of Covid-19. We are committed to ensuring a healthy environment for all our families.

_____ *Initial*

BAD WEATHER

In the event of severe weather, we will follow the **Keller ISD Weather Cancellation Policy** (Keller clinic) or **Northwest ISD Weather Cancellation** (Justin clinic), not the school calendar. Please watch your local news stations for this information.

_____ *Initial*

TREATMENT SESSIONS

Each session will include communication with your therapist regarding your child's progress or your concerns, direct one-on-one therapy with the therapist, and instruction for home activities. **Your child may be dismissed during the last 5 minutes of the session** in order for the therapist to have the opportunity to document progress toward goals and to plan for the next visit.

_____ *Initial*

THERAPIST CANCELLATIONS

Sometimes there are reasons that your therapist is not available. If your therapist is ill or out of the office, your child will be rescheduled with another therapist at the same time. The covering therapist has access to your child's goals and treatment plans. If the same time is not available, you will be contacted to reschedule for a different day/time.

PRIVACY POLICY

_____ (HIPAA *initial*

I acknowledge that I have received and reviewed information on the Notice of Privacy Practices Notice).

TREATMENT AREAS

_____ *Initial*

In order to ensure that patients have access to all areas needed for their care, and to ensure the safety of all guests within our building, children other than the patient are not permitted into treatment areas. They should remain in the lobby with supervision of a parent or guardian. Parents are permitted into the session in order to observe and for instruction in home programs. Please limit the number of adults observing a session to one.

_____ *Initial*

PARENT/GUARDIAN ON THE PREMISES

For the safety of your child, we require that a parent or guardian remain on the premises at all times that the child is in a therapy session. Children in the lobby must be accompanied by an adult. Please do not plan to drop off your child or run errands during their appointment time.

I acknowledge that I have reviewed and accept the above policies.

_____

Parent Signature *Date*