TheraSuit Method® Summary

TheraSuit® and the TheraSuit Method® is an Intensive Therapy Program, offered for 3-4 hours per day, 5 days a week for 3 weeks. This program will utilize The TheraSuit Method®, a holistic approach to treatment for those with neurological disorders like Cerebral Palsy, Developmental Delays, and Traumatic Brain Injuries. The key element of this method is an intensive strengthening program established for the participant based on his individual needs, strengths and weaknesses. TheraSuit Method® is based on an intensive and specific exercise program aimed at the elimination of pathological reflexes and establishing new, correct, and functional patterns of movements. This intensive program is essential to provide consistency of therapeutic intervention and increased repetition of exercises necessary for significant muscle and neurological retraining.

TheraSuit Method® utilizes various tools and exercises, including the TheraSuit® and Universal Exercise Unit. The TheraSuit® is a breathable, soft dynamic orthotic used to improve and change proprioception, reduce pathological reflexes, restore physiological muscle synergies and load the entire body with weight similar to a reaction of our muscles to the gravitational forces. Universal Exercise Unit is used to train and isolate desired patterns of movement to specifically strengthen the muscle groups responsible for that movement. Universal Exercise Unit works to improve range of motion, muscle strength and joint flexibility, as well as functional skills. This program is provided on a one-on-one basis with our licensed, TheraSuit® certified therapists. After completion of the intensive program, a complete, individualized home program will be provided with detailed education to the patient and parent.

For entry into the program, our licensed, TheraSuit® certified therapists must screen, evaluate, and recommend the patient for inclusion in the program. The Therapy Place has both Physical Therapists and Occupational Therapists TheraSuit Certified®. The following is a list of indications to help determine if you believe your child is a good fit for our program. In addition, the child must have clearance from his or her physician.

Indications:

- Cerebral Palsy
- Developmental delays
- Traumatic Brain Injury
- Post stroke (CVA)
- Ataxia
- Athetosis
- Spasticity (increased muscle tone)
- Hypotonia (low muscle tone)
- Hypertonia (high muscle tone)
- Other neurological disorders and syndromes (Spina Bifida, Down Syndrome

PLEASE NOTE: A child does NOT have to be a current patient at The Therapy Place to participate in TheraSuit Method at The Therapy Place. They may resume services with their regular PT/OT provider following completion of TheraSuit Method. Please send all questions and completed medical screens to therasuit@thetherapyplace.org

Please see our web site to learn more and to see videos of previous children who have participated in this innovative program: thetherapyplace.org.

TheraSuit Checklist for Parents

Below is the list of steps required for your child to participate in this program:

1. Please complete the **medical screen** form completely and thoroughly and return to us by either mail or fax. We cannot proceed without receiving this completed form.
    a. Mail: 3620 Covenant Road, Columbia, SC 29204
    b. Fax: (803)787-0300
2. After the completed medical screen form is received in our office, one of our therapists will contact you by phone to review the information and to make a preliminary decision as to whether your child is a good candidate for the TheraSuit Method®.
3. **Please note, a hip x-ray within the last 6 months and clearance from an orthopedic surgeon is required.**
4. If it is determined that your child is a candidate, you will receive a call from our scheduling coordinator to set up the initial 1-hour evaluation in our office.
5. The therapist will then write a Letter of Medical Necessity and send it to your child's pediatrician and/or orthopedic surgeon for medical clearance. You will receive a copy of this letter at the end of the 3 weeks.
6. If your child is cleared to participate in the program, our lead TheraSuit Therapist will offer specific dates to your family.
7. Once you accept these dates, the Therapist will write and send the LMN to your pediatrician no less than 2 weeks before the start date.
8. If your child currently receives Physical or Occupational Therapy in our office on a weekly basis, those appointments will be put on hold until the end of the three-week TheraSuit session due to the intensity of the TheraSuit Method®.
9. Parents and/or caregivers are welcome to stay with the child throughout the session unless the therapist determines it is a distraction for the child.
10. Please feel free to contact us at (803) 787-3033 or therasuit@thetherapyplace.org if you have any further questions after reading these steps.

Medical Screen - TheraSuit®

Date:_____

Patient name: _____ Date of birth:_____

Primary Diagnosis: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____State: _____Zip:_____

Home Phone: ( )_____Cell Phone: ( )_____

Parent/Legal guardian: _____

Relation to patient: _____E-mail: _____

Primary language: _____ Interpreter needed: ☐ Yes ☐ No

Additional contact person: _____Phone: ( ) _____

Primary care physician: _____

_____

_____

Referring physician: _____

_____

Specialist(s): _____

_____

_____

_____

_____

_____

Therapy currently receiving: ☐ OT ☐ PT ☐ SLP Where? _____

_____

_____

Date of hip x-ray report (**MUST be no older than 6 months**) _____ ☐ attached

- **Attach any other available test or therapy reports (x-ray, MRI, CAT scans, EMG, PT, OT, etc.)**

MEDICAL HISTORY

1. Diagnoses (List all):_____

_____

_____

2. List any medication your child is taking and reason for taking it:_____

3. Medical / Surgical History:

- Recent surgeries/hospitalizations: _____

- Bone demineralization (Osteoporosis)? _____

- Allergies (Latex? List all): _____

- Botox / Phenol Injections (Dates): _____

- Inhibitive / Serial Casting (Dates): _____

- Fractures/Contractures (Location / dates): _____

- Rhizotomy (Date): _____

- Muscle Lengthening (Location / dates): _____

- Seizures (Severity and date of last one): _____

- Heart Problems / Hypertension / Heart Surgeries: _____

- Breathing / Lung Problems (Is your child on any monitors or oxygen? Tracheostomy? Asthma? Steriods?):

- Diabetes (Type 1 or Type II? Insulin?): _____

- Sensation / Loss of Feeling (Location): _____

- Scoliosis (Location / Degree): _____

- Vision / Hearing:_____ Glasses_____ Hearing Aides_____

_____

- Shunts (Hydrocephalus): _____

- G-Tube / Feeding Problems / Restrictions: _____

_____

- Kidney Problems (Catheterized?): _____

-Other: _____

_____

4. Child's abilities (check what your child can do):

- ☐ Roll over independently
- ☐ Sit independently
- ☐ Assume sitting independently from lying down
- ☐ Crawl
- ❑ Stand:_____ holding on _____independently
- ❑ Walk:_____ holding hands _____independently
- ❑ Other: _____

5. List any medical equipment that your child is utilizing (such as braces / splints, standers, walkers - what type, crutches, canes, wheelchairs, etc.):_____

_____

_____

6. How do you communicate with your child / how do they communicate with you? _____

_____

Can your child follow 1-step commands? ☐ Yes ☐ Sometimes ☐ No

Can your child follow 2-step commands? (for example- first…, then…) ☐ Yes ☐ Sometimes ☐ No

Can your child follow complex commands? ☐ Yes ☐ Sometimes ☐ No

Is your child able to move his or her body parts (for example, arms, legs, head) upon request?

☐ Yes ☐ Sometimes ☐ No

7. What motivates your child? (for example, favorite toys, bubbles, TV, praise)_____

_____

8. What are the patient/family goals the Intensive Strengthening Program?_____

_____

_____

9. Why do you think that this is an appropriate time for your child to have an intensive program? _____

_____

_____

_____

10. Has your child ever been denied therapy at a clinic that provides intensive therapy?

____ Yes _____No (If yes, explain when and why)

_____

_____

When your completed application is received, it will be clinically reviewed. You will be advised of the outcome and the scheduling process will begin. If you have any questions, please contact The Therapy Place (803) 787-3003 or email: therasuit@thetherapyplace.org

Fax this completed form to: The Therapy Place at (803) 787-0300 or

email to: therasuit@thetherapyplace.org

Parent/Caregiver Signature: _____

Date: _____

If your child is *not currently an active patient at The Therapy Place,* your child will be scheduled for an evaluation. (If your child IS currently an active patient at The Therapy Place, you do not need to schedule an evaluation.)

Evaluations will typically last between 45 minutes to 1 hour. We request the parent/patient arrive 15-20 minutes prior to the scheduled time to complete necessary patient information. We also ask the parent or caregiver to remain present during all evaluations to provide relevant history and information to the therapist as requested. Please bring any previous therapy or discharge paperwork that may be helpful in documenting your child's medical history.

Following the evaluation, the therapist will formally determine the child's eligibility for inclusion in the TheraSuit program. If the child is approved, the parent will be provided with further policy and procedure information and be scheduled for a 3-week session, as able. Following scheduling, the therapist will provide a letter of medical justification for inclusion in the program for pediatrician signature. The parents will be provided with a copy of this letter for any insurance/payment purposes.

The Therasuit Method® Payment

The Therapy Place will bill **BlueChoice Medicaid** or "**regular"/Fee for service Medicaid** for TheraSuit®/Intensive services. Should your child also have a commercial plan, as with all therapy services, we must first bill that plan before Medicaid.

***** You will be responsible for bringing any EOBs and/or Checks from your insurance to The Therapy Place immediately upon receipt. *****

Name of Primary Insurance (*if other than Medicaid*):
_____

Primary Insured's Name: _____ Primary Insured's DOB: _____

Policy #: _____

Circle Type of Medicaid: Medicaid FFS/TEFRA *BlueChoice*

Medicaid Policy #(s):
_____

If you have BLUECHOICE, then you should have two (2) different insurance cards. We will need to make a copy of both. Thank you

The Therapy Place is a Medicaid facility accepting BlueChoice and Fee for Service or "Regular" Medicaid. We do not *participate* in any private insurance plans. If you have private insurance in addition to Medicaid, we will bill your primary (Medicaid is secondary), accept any payment rendered and then bill Medicaid for the balance.

By signing below, you are accepting terms of TTP's Financial Policy as described above.

_____ _____
Child's Name Date of Birth

_____ _____
Signature of parent or legal guardian Date

_____ _____
Please print name of person signing Relationship to child

ASSIGNMENT OF INSURANCE BENEFITS

CHILD'S NAME: _____

PRIMARY INSURANCE NAME: _____

SECONDARY INSURANCE NAME: _____

By signing the form below, I am allowing The Therapy Place to submit claims on my child's behalf and receive payment for services rendered to my child.

1. I understand that signing this form authorizes The Therapy Place to submit claims on my (or my child's) behalf directly to Medicaid or my private health insurance provider. The Therapy Place will accept assignment of these benefits. The Therapy Place will receive direct payment for services provided.
2. I also understand that signing this form authorizes the release of medical or other information to my health insurance providers and The Therapy Place as necessary to complete the billing process.

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Child

Patient Billing Contract
FOR THOSE WITH PRIVATE INSURANCE AND MEDICAID

I, _____ (name of responsible party - parent/guardian) understand that The Therapy Place Inc. does not participate with my child's primary insurance.

_____ (initials) I understand that to file my child's claims to his/her secondary Medicaid, The Therapy Place Inc. MUST have the processing information (EOB) and payment (if applicable) from the primary insurance carrier. Because The Therapy Place does not participate with my child's primary carrier, I understand that my child's primary insurance carrier may send all processing information and/or payments (checks) *directly to me* instead of to The Therapy Place Inc.

_____ (initials) I understand that I am required to bring in each Explanation of Benefits and each check payment from my primary insurance carrier to The Therapy Place **within 30 days of the date on the EOB and/or check.**

_____ (initials) I understand that if I fail to do this on a regular basis and within the time allotted, The Therapy Place Inc. will have no choice but to stop providing services to my child, as they will be unable to obtain payment for services from my child's Medicaid.

_____ (initials) I understand that if I have any questions about this process and require any assistance regarding this contract, I can contact the Billing Manager, Teresa Fleming, at 803-546-0567 or and/or speak to Dawn during office hours.

Please provide email address for monthly email reminders:

_____

By signing below, I acknowledge the terms of the above billing contract. I understand that payments made to me on behalf of services rendered by The Therapy Place may be surrendered to TTP directly (by signing the back) OR I will deposit checks and make payment directly.

_____ _____

Signature of Legal Guardian/Responsible party Date

_____ _____

Please print name of person signing Relationship to child

TheraSuit® Schedules, Attendance and Cancellation Policies

SCHEDULING: There are both morning and afternoon sessions. Therapists and our scheduling coordinator will work with you to determine the time we have available that will also fit your schedule.

ILLNESS/TARDINESS/CANCELLATIONS:

1. If your child becomes ill before the session begins and is not able to attend, the child will receive a full credit toward a future session within one calendar year. Documentation from the child's physician is required.
2. If your child becomes ill during a session and is unable to continue to finish the entire session, we will work with you to have the child make up remaining days/weeks missed as schedule permits into another session when your child is healthy.
3. If your child becomes ill during a session and misses one or a few days and is able to return back to the session, those days will not be made up.
4. If your child is tardy for a session, it is the therapist's discretion to make-up the time missed. No sessions will run past 12pm.
5. If the therapist is out, we will work with you to have the child make up the missed time as the schedule permits into another session.
6. If your child's session falls on an observed holiday of The Therapy Place, TheraSuit® will not occur on that day. We do our best to offer dates that do not include observed Holidays.

Therapy Attendance Policy

Out of concern for your child and the wellbeing of others, please do not bring your child if they have experienced:

- **A fever of 100° or higher within the last 48 hours**
- **Vomiting or diarrhea within the last 48 hours**
- Infectious conditions, such as, chicken pox, scabies, or lice
- Pink eye/Strep Throat (may return to therapy after being treated with appropriate antibiotic therapy for 24 hours)
- A seizure after which your child is not alert enough to participate in therapy

I have read and understand the above therapy attendance policy.

_____ _____

Signature of Legal Guardian/Responsible Party Date

Emergency Contact Information

Participation in the Therapies and the Bridges Program, therapy and/or activities requires various degrees of exercise and movement that may be new to the individual participating. I understand that these activities may result in injury to a person or child and hereby hold harmless The Therapy Place, its staff and volunteers from any injury resulting from the careful and responsible implementation of such activities.

Child's Name: _____ DOB: _____

Allergies/Special concerns/instructions (may include seizure instructions, etc.):

_____

_____

_____

CONTACT INFO:
"Primary" Parent/Guardian Name:

_____

Primary Email:

_____

Phone 1: _____ Phone 2:_____

Address:

_____

"Secondary" Parent/Guardian/Emergency Contact Name:

_____

Relationship to Child:

_____

Phone 1: _____ Phone 2: _____

We require that a parent/guardian remain in the building during therapies (other than Bridges or TheraSuit). Should an emergency occur and you are not in the building, we will contact 911 and the child will be transported to the Palmetto Health Children's Hospital. A staff member will accompany your child until parent or guardian arrives. You will be notified immediately.

Name of person filling out form: _____
Relationship to Child: _____

Parent Release Form for Media Recording

I, _____, do hereby grant/deny permission to The Therapy Place to

use the image of my child, _____, as marked by my selection(s) below. Such use includes the display, distribution, publication, transmission, or other use of photographs, images, and/or video taken of my child for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on The Therapy Place Web site.

❑ Deny permission to use my child's image at all.

❑ Grant unrestricted permission to use my child's image in connection with The Therapy Place. I give unrestricted permission for my child's image to be used in print, video, and digital media. I agree that these images may be used by The Therapy Place for a variety of purposes and that these images may be used without further notification. These purposes include, but are not limited to:

- ✓ The Therapy Place Social Media
- ✓ The Therapy Place print/marketing materials

I understand that the child's surname will not be used in conjunction with any video, printed, or digital images.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Print Name Relationship to Child

If you have any questions about the above, please let staff know.

CONFIDENTIALITY NOTICE

List all INDIVIDUALS who may accompany your child for treatment and/or receive medical information (other than legal guardians already listed on account and medical record). Please include name and relationship to the patient.

NAME: Relationship:

_____

_____

_____

I understand that any person who is not a legal guardian of my child or whose name does not appear on the above list will not be given access to any medical information, or be allowed to accompany my child for treatment without further written permission.

Please list any other PROFESSIONALS who may share your child's medical information. This includes TTP receiving information from professional or providing to information to professional.

NAME: Practice:

_____

_____

_____

_____

CONFIDENTIALITY DURING TREATMENT/DISCUSSION OF THERAPY -- At this facility, many of our therapy sessions take place in a large open gym that is shared with other patients, patient family members and therapists. Following therapy, the therapist will come out to the lobby to share your child's progress with you. Because of these circumstances, others may hear information about your child. At any time, you are welcome to request that your child receives therapy in a private enclosed area and that the therapist discuss progress with you privately.

Please check your preference regarding open treatment/discussion:

_____ My child may be treated in the open gym. I understand I can always speak to his/her therapist privately.

_____ I would prefer that my child be treated in a separate/private area.

PRIVACY POLICY:

_____ (Initials) I was offered a copy of the Privacy Policies of TTP and understand a copy is available at the front desk at any time.

_____ _____

Parent/Guardian Signature Date

_____ _____

Child's Name Relationship to Child

AUTHORIZATION AND CONSENT TO TREAT A MINOR

The undersigned does hereby authorize The Therapy Place consent to exam and treat the below mentioned minor by employees of The Therapy Place without a Parent or Guardian present.

_____ _____

Parent/Guardian Signature Date

_____ _____

Child's Name/ DOB Relationship to Child

_____

Child's Name

_____ _____

Parent signature Date

_____ _____

Witness signature Date

Revised June 2024