Today's Date: _____

NEW PATIENT INTAKE PAPERWORK

****Please let staff know if you have any questions.****

Child's Full Name: _____ DOB: _____

Diagnosis: _____

Referring Physician Practice Name: _____

Referring Physician Name: _____ Physician Phone: _____

Pediatrician (if different from referring): _____

Parent/Caregiver Name #1: _____ Occupation: _____

Biological: _____ Adoptive: _____ Adoption Date: _____

Home Address: _____

City: _____ State: _____ Zip code_____

Home Phone #: _____ Work #: _____ Cell #: _____

Email: _____

Parent/Caregiver Name #2: _____ Occupation: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Email: _____

INSURANCE

Name of Primary Insurance: _____

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

Policy #: _____

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

Medicaid Policy #: _____

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

Patient Name:_____ **DOB:**_____

Why are you seeking treatment for your child? (challenges/goals)

_____
_____
_____
_____

Medical History

Was your child born full term? **Y ☐ N ☐** If no, how early?_____ Birth weight?_____

C-Section? Y ☐ N ☐ NICU stay**? Y ☐ N ☐** If so, how long? _____

Any medical interventions following birth?

_____
_____
_____

Were there complications during pregnancy/delivery/labor? Please describe:

_____
_____

Please describe any significant medical history or additional diagnoses:

_____
_____

Please list any medications you child currently is taking and the reason for taking:

Medication: **Use/Reason for taking:**

_____
_____
_____
_____
_____

Please list any food or environmental allergies your child may have:

_____
_____
_____

Please list medical specialists (i.e., neurologist, orthopedist, psychologist, etc.):

_____
_____
_____
_____
_____

Patient Name:_____ **DOB:**_____

Please list any surgeries you child has had and the reason/outcome:
Surgery/Outcome: **Date:**

_____
_____
_____
_____

Does your child receive any interventions? Botox? Baclofen oral or pump, etc?

_____
_____

Has your child ever been diagnosed with epilepsy? **Y ☐ N ☐** Has your child ever had a seizure? **Y ☐ N ☐**

If so, when was the last one? _____ Please describe your child's seizures – how often/ duration/ symptoms, etc:

_____
_____
_____

How do you handle the seizure while occurring and immediately after? _____

_____

Other Concerns – Examples include ASTHMA, REFLUX, EXCESSIVE PAIN – please explain:

_____
_____

Does your child have any problems with his or her eyes/vision? **Y☐ N☐** When was the last screening? _____

Please explain: _____

Does your child have any problems with his or her ears/hearing? **Y☐ N☐** When was the last screening? ____

Please explain: _____

FAMILY/SOCIAL HISTORY

Who lives in the home? (Please give ages of siblings) _____

Does your child attend school or daycare? **Y☐ N☐** If so, name of school: _____

Grade: _____ Type of Program: _____

Patient Name: _____ DOB: _____

Does your child currently receive therapy at another location? **Y ☐ N ☐**
If yes, which type of therapy? **PT ☐ OT ☐ Speech ☐** Other: _____
Will the therapy continue? **Y ☐ N ☐**
If yes, where and when is the other therapy received? _____ (name of school or clinic)

TTP will not get paid to see your child for therapy on the same day that he/she gets the <u>same</u> therapy (physical, occupational or speech) at another location (school, another clinic, etc.). Insurance will only pay for 1 visit per day of a therapy. Please make sure that your child's school schedules his/her therapy around the schedule you have set here with The Therapy Place.

Has your child previously received therapy? **Y ☐ N ☐** Date of discharge: _____

Reason for discharge: _____

DEVELOPMENTAL HISTORY – answer these sections to the best of your memory, particularly those that are relevant to the therapy requested.
Please list the approximate age your child achieved the following developmental milestones:

Sat alone:_____ Crawled: _____ Rolling:_____ Walked: _____ Toilet Trained: _____
Finger Fed themselves: _____ Spoon/Fork Fed themselves: _____
Dressed themselves: _____ Single Words:_____ Combined Words:_____

Does your child eat by mouth? **Y ☐ N ☐** G-Tube? **Y ☐ N ☐** Is your child on a special diet? **Y ☐ N ☐**
If so, please specify: _____

Food Allergies: _____

Food Aversions: _____

Concerns/Special Notes re: Diet: _____
_____
_____
_____

Speech-Language Development (check all that apply)
<u>Did/does your child:</u>

- ☐ Coo, babble
- ☐ Imitate sounds, words, phrases
- ☐ Imitate gestures
- ☐ Understand simple directions
- ☐ Uses sign language
- ☐ Retrieve/point to common objects upon request
- ☐ Answer simple questions
- ☐ Respond appropriately to yes/no questions

What method of communication does your child use? (e.g., signing, verbal, etc.) _____
Communication system/device: _____
Concerns/Special Notes re: Speech/Language: _____

_____

Patient Name:_____ **DOB:**_____

Gross Motor Development (check all that apply)

Did/does your child:

☐ Lift head while on stomach ☐ Bear weight on legs ☐ Bear weight on arms
☐ Roll over ☐ Stand holding on ☐ Stand alone
☐ Throw a ball ☐ Run
☐ Jump ☐ Walk up/down steps

Concerns/Special Notes re: Gross Motor: _____
_____
_____

Fine Motor Development (check all that apply)

Did/does your child:

☐ Hold objects in hand ☐ Reach for objects ☐ Clap hands ☐L ☐R Hand preference
☐ Draw ☐ Pick up small object ☐ Manipulate fasteners ☐ Point at objects

Concerns/Special Notes re: Fine Motor: _____
_____
_____

Sensory (check all that apply)

Did/does your child:

☐ Have trouble falling asleep ☐ Avoid being touched
☐ Engage in self-stimulating behaviors ☐ Hear things most people tune out
☐ React negatively to "normal" noises ☐ Refuse to wear certain clothing/bothered by shirt tags or sock seams
☐ Fall frequently/clumsy ☐ Is always in motion
☐ Dislike certain temperatures/textures ☐ Toe walks
☐ Picky eater ☐ Covers ears
☐ Bites/mouths things ☐ Dislikes haircuts/nail trimming
☐ Seeks spinning ☐ Constantly talks/hums

Concerns/Special Notes re: Sensory: _____
_____
_____

ADDITIONAL INFORMATION

Does your child have any medical equipment/aides currently? (Ex: communication device, wheelchair, braces, etc..)

_____
_____
_____
_____
_____

Patient Name: _____ DOB: _____

Is your child toilet trained? **Y ☐ N ☐** Notes: _____

Activities of Daily Living: Does your child need HELP with any of the following:
Dressing? **Y ☐ N ☐** Toileting? **Y ☐ N ☐** Brushing teeth or hair? **Y ☐ N ☐** Self-feeding? **Y ☐ N ☐**

What are your child's likes/what motivates them: _____
_____
_____

What are your child's dislikes? _____
_____
_____

Does your child have any behavioral difficulties, for example, biting, hitting? **Y ☐ N ☐**

If so, please specify: _____
_____
_____

What method of discipline is used at home, for example "time out"? _____
_____
_____

Name of person filling out paperwork: _____

Relationship to Child: _____

_____ _____
Parent/Caregiver Signature Date:

Emergency Contact Information

Participation in Therapy and the Bridges Program, 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? (If seizures are a concern, please ask staff for a seizure protocol form to fill out)

_____

_____

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. The parent listed above will be notified immediately.

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

_____ _____
Parent/Caregiver Signature Date:

The Therapy Place, Inc.
3620 Covenant Road
Columbia, SC 29204

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

The Therapy Place, Inc.
3620 Covenant Road
Columbia, SC 29204

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 tfleming@thetherapyplace.org and/or speak to Brooke Proctor 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

The Therapy Place, Inc.
3620 Covenant Road
Columbia, SC 29204

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.

Therapy Attendance Policy

We are so happy that you have chosen The Therapy Place for your child's therapy service. In order to provide your child and other children with the best therapy service possible, we would like you to understand our therapy attendance policy. Consistency and regular attendance is the key to making your child's therapy a success. After reading each section, please initial in the lines provided under each section.

Regular Attendance:

It is required that your child attends **75%** of his/her scheduled treatment sessions. For example, if your child is seen 1x per week, 4 times per month, this equals 12 visits within a quarter. He/she cannot have more than 3 absences within that quarter to meet the 75% rule. If your child misses more than 25% or is consistently late, it will result in your child's name being removed from the therapy schedule. _____

Tardiness:

Children arriving up to 15 minutes late for a 1-hour session and 5 minutes late for a 30-minute session to therapy will be treated for the remainder of their allotted treatment slot. However, if your child is more than 15 minutes late for a 1-hour session and more than 5 minutes late for a 30-minute session to therapy it is up to the therapist's discretion to complete treatment for that day. If it is deemed not enough productive billable time it will be counted as an absence.

_____

Cancellations

We understand that because of illness and other unexpected events, it may be necessary to cancel therapy. Please notify the center as soon as possible if you need to cancel your child's therapy appointment. We request that cancellations be made 24-hours prior to the appointment. If we do not receive a cancellation prior to 3 hours before the scheduled time it will be logged as a last-minute cancellation. Three or more last minute cancellations within a year may cause your child to lose their weekly therapy session. We do realize that is not always possible and will take extenuating circumstances into consideration.

- Therapist/Center Cancellations: If your therapist needs to cancel TTP will call you as soon as possible to inform you. Attempts will be made to reschedule if possible. Treatment sessions cancelled by your therapist will not count against your attendance percentage. _____

Out of concern for your child and the wellbeing of others, please do not bring your child if he/she has 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 and fever free for 24 hours)
- A seizure after which your child is not alert enough to participate in therapy

Make- Up Sessions:

Please note that TTP will try to reschedule any therapy sessions that are missed, either by patient or therapist cancellation. We will try to reschedule with your normal treating therapist; however, it may be that your child has to see another therapist within the same discipline. Please note that these therapists are experienced professionals, and they will fully study your child's chart before seeing them. _____

Vacation Policy:

We request notification of dates of vacation at least 14 days prior to the date which will be missed. Please not that we may not be able to hold your timeslot for more than 2 weeks in a row. _____

No show/No call:

Two "no show" appointments will result in your child being **Removed** from the therapy schedule. Please call if you are not able to keep your child's therapy appointment. If you want your child to receive reoccurring therapies again we would need another referral from your doctor and will contact you when a spot becomes available.

_____

We are very excited to be working with you and your child. Please call with any questions or concerns regarding the therapy attendance policy.

I have read and understand the above therapy attendance policy.

_____	_____	_____
Parent/Guardian Signature	Date	Child's Name

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 we 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 posted in the lobby or one will be 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