

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: _____

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 your 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? Yes No

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 same 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)

Did/does your child:

- | | |
|---|--|
| <input type="checkbox"/> Coo, babble | <input type="checkbox"/> Uses sign language |
| <input type="checkbox"/> Imitate sounds, words, phrases | <input type="checkbox"/> Retrieve/point to common objects upon request |
| <input type="checkbox"/> Imitate gestures | <input type="checkbox"/> Answer simple questions |
| <input type="checkbox"/> Understand simple directions | <input type="checkbox"/> 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:

- | | | |
|---|--|--|
| <input type="checkbox"/> Lift head while on stomach | <input type="checkbox"/> Bear weight on legs | <input type="checkbox"/> Bear weight on arms |
| <input type="checkbox"/> Roll over | <input type="checkbox"/> Stand holding on | <input type="checkbox"/> Stand alone |
| <input type="checkbox"/> Throw a ball | <input type="checkbox"/> Run | |
| <input type="checkbox"/> Jump | <input type="checkbox"/> Walk up/down steps | |

Concerns/Special Notes re: Gross Motor: _____

Fine Motor Development (check all that apply)

Did/does your child:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Hold objects in hand | <input type="checkbox"/> Reach for objects | <input type="checkbox"/> Clap hands | <input type="checkbox"/> L <input type="checkbox"/> R Hand preference |
| <input type="checkbox"/> Draw | <input type="checkbox"/> Pick up small object | <input type="checkbox"/> Manipulate fasteners | <input type="checkbox"/> Point at objects |

Concerns/Special Notes re: Fine Motor: _____

Sensory (check all that apply)

Did/does your child:

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

FINANCIAL POLICY

The Therapy Place *does not* participate in private insurance plans. We only accept Medicaid FFS/TEFRA and the BlueChoice health plan. If you have any other Medicaid plans or only private insurance, your child will be considered a Private Pay patient.

Payment is expected in full, at the time service is rendered. *****Please note that your child will not be able to be seen if you have an outstanding balance and therapy spots will not be held for more than 1 week*** Private pay patients will receive a 25% discount for paying at the time of service. This savings is in part due to no administrative filing burden on TTP.** Upon request, The Therapy Place will provide copies of the medical documentation for you to submit to your private insurance for possible reimbursement. This service is provided free of charge. Please let the front desk know and provide an email address or you may receive at subsequent visits.

TREATMENT CHARGES ARE AS FOLLOWS:

Physical, Occupational or Speech Evaluation: \$150 (112.50 for discount private pay)
Physical, Occupational or Speech Therapy Session: \$30 per unit/15 minutes or \$120 per hour
($\$22.50$ per unit/15 minutes; $\$90$ for 1-hour private pay discount)

*****If you are scheduled for an evaluation/therapy session and are unable to attend and you do not call to cancel ahead of time your card on file will be charged a \$50 no show fee*****

In order to receive the discount, you must have a card on file.

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

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 to therapy will be treated for the remainder of their allotted treatment slot. However, if your child is more than 15 minutes late 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 note 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