

PARENTS/ GUARDIANS

**YOUR SIGNATURE IS REQUIRED FOR OUR FILES ON EACH OF THE
FOLLOWING SHEETS**

**A COPY OF EACH SHEET WILL BE MADE AVAILABLE TO YOU UPON YOUR
REQUEST**

SIGN & RETURN SECTION

- VERIFICATION OF RECEIPT OF PARENT PACKET INTAKE INFORMATION TEAR OFF
- INTAKE FORM
- INSURANCE INFORMATION
- SENSORY PROFILE
- DEVELOPMENTAL HISTORY AND EVALUATION OF SENSORY PROCESSING
- AUTHORIZATION TO RELEASE INFORMATION
- POLICY STATEMENT
- ATTENDANCE POLICY
- CANCELLATION LATE FEES & SERVICES CHARGES
- NOTICE OF PATIENT INFORMATION PRACTICES
- VIDEO/PHOTO RELEASE
- HIPPA COMPLIANCE

✂ Please sign and return

I have read the enclosed information provided to me and understand and agree to abide by all policies and procedures as described.

Child's Name: _____

PARENT/ GUARDIAN SIGNATURE _____ **Date:** _____



11011 Sheridan Street, Suite 302
Cooper City, Florida 33026

Phone: 954.499.1125
Fax: 954.499.1123
Toll Free: 866.499.1125

INTAKE FORM

Today's Date: ___/___/___

PLEASE PRINT AND COMPLETE ALL APPLICABLE FIELDS

Child's Name: _____ Social Security Number: _____
LAST FIRST

Date of Birth: ___/___/___ Age: _____ Sex _____

Address _____ City _____ State _____ ZIP _____

Parent's Home: (____) _____ - _____ Parent's Work: (____) _____ - _____

Parent's Mobile: (____) _____ - _____ Other: (____) _____ - _____

Referral for Occupational Therapy Physical Therapy Speech Therapy

Father's Name: _____ Mother's Name: _____
LAST FIRST LAST FIRST

Occupation: _____ Occupation: _____

Address: (if different from child's) _____ Address: (if different from child's) _____

City State Zip City State Zip

Emergency Contact Name: _____ Phone Number: (____) _____ - _____

Caregiver's Name: _____ Phone Number: (____) _____ - _____

Siblings Names and Ages: _____

Position of child in relation to siblings: _____

Any relatives with similar problems: _____

Pediatrician's Name: _____ Phone #: (____) _____ - _____

Address: _____ City _____ State _____ ZIP _____

Name of the professional who referred you to us: _____

Child's Diagnosis _____

Primary

Secondary

Reason for Referral: _____

Has your child received therapy for the condition? YES NO

If YES please indicate what kind of therapy service: Occupational Therapy Physical Therapy Speech Therapy

Can we obtain copies of therapy reports? YES NO



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INSURANCE / MEDICAID INFORMATION

1) Name of Primary Insurance Company _____

ID# _____ Name of Insured _____

Group # _____ Phone #: (_____) - _____ - _____

Relationship to Insurance _____

2) Secondary Insurance Company Name (If Applicable): _____

ID# _____ Name of Insured _____

Group # _____ Phone #: (_____) - _____ - _____

Relationship to Insurance _____

3) Third Insurance Company Name (If Applicable): _____

ID# _____ Name of Insured _____

Group # _____ Phone #: (_____) - _____ - _____

Relationship to Insurance _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to **SPECTRUM THERAPY SERVICES** all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize the use of this signature to release medical records to primary physician and/or health insurance company.

Responsible Party's Signature

Relationship

Date



DEVELOPMENTAL HISTORY AND EVALUATION OF SENSORY PROCESSING

This questionnaire will assist *Spectrum Therapy Services* therapists in gathering significant information about your child's history and functioning within age appropriate environments such as school, home and the community. This information is used to interpret test results and observations during the evaluation process. If you have any comments or questions regarding this questionnaire please feel free to contact *Spectrum Therapy Services* and your question(s) will be directed to the appropriate therapist. Thank you.

Prenatal History

Mother's age at birth of child _____ Father's age at birth of child _____

Complications during Pregnancy: _____

Complications during Delivery: _____

Comments: _____

Did mother take any medications during pregnancy? YES NO If Yes please list _____

Birth History

<input type="checkbox"/> Full Term Birth Weight: _____ <input type="checkbox"/> Premature	If Premature, Please give Month: _____ Weight _____	<input type="checkbox"/> Natural delivery <input type="checkbox"/> Cesarean Birth
Was labor: <input type="checkbox"/> Prolonged <input type="checkbox"/> Short <input type="checkbox"/> Within normal range <input type="checkbox"/> Induced APGAR score if known: _____	Were forceps used? _____ Medication During delivery _____ _____	Were there other complications such as: <input type="checkbox"/> Breathing difficulties <input type="checkbox"/> Sucking/Feeding difficulties <input type="checkbox"/> Intubated <input type="checkbox"/> Incubation <input type="checkbox"/> Transfusion <input type="checkbox"/> Congenital defects

Was your child breast fed? YES NO If Yes, how many weeks/months/years _____

Did your child have difficulty breast feeding? YES NO If Yes, what were the difficulties _____

Did your child have difficulty using the bottle? YES NO If Yes, what were the difficulties _____

Medical History

Childhood Illness (Please check all that apply)

- | | | | |
|-----------------------------------------|---------------------------------------|-------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Respiratory Infections | <input type="checkbox"/> High Fevers |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Other: _____ |

PLEASE LIST:

Allergies: _____

Physical Injuries: _____

Medications your child takes regularly: _____

Medical diagnosis (diabetes, epilepsy, heart problems, autism, ADHD, ADD): YES NO

If other, please list: _____

Has your child had any surgeries? YES NO If yes, please list type and approximate date:

Has vision been tested? YES NO Date _____ Results _____

Has hearing been tested? YES NO Date _____ Results _____

Has a neurological evaluation been performed? YES NO Date _____ Results _____

Has a Sensory Integration Praxis Test (SIPT) been completed? YES NO Date _____

Has a Speech/Language Evaluation been performed? YES NO Date _____

Has a Psychological Evaluation been performed? YES NO Date _____

Has a Behavioral Evaluation been performed? YES NO Date _____

Has your child been seen by an ENT (Ear Nose Throat)? YES NO Date _____ Results _____

Has your child received any services by other agencies/programs (Early Intervention Program, Head Start, Mommy and Me)? If other, please list: _____

Who is your child's pediatrician? _____ Location: _____

Has your child received therapy services before? If yes, please specify type of therapy and list dates and length of time: _____

Other medical information you feel we should be aware of: _____

Developmental History

Please list age at which your child:

Rolled over: _____ Sat Independently _____ Crawled _____ Stand _____ Walked _____

First word _____ Two-word combination _____ Sentences _____

Check behaviors which described your child as an infant:

- | | |
|--------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Cried a lot, fussy, irritable | <input type="checkbox"/> Resisted to be held |
| <input type="checkbox"/> Good, non-demanding | <input type="checkbox"/> Floppy when held |
| <input type="checkbox"/> Alert | <input type="checkbox"/> Tense when held |
| <input type="checkbox"/> Quiet or passive | <input type="checkbox"/> Very active |
| <input type="checkbox"/> Liked being held | <input type="checkbox"/> Regular sleep patterns |
| <input type="checkbox"/> Drooled excessively | <input type="checkbox"/> Irregular sleep patterns |



General:

At the present age of your child:

Are you concerned about your child's communication? YES NO
How does your child communicate (gestures/words)? _____
How does your child express his/her wants and needs? _____
What words/sentences does your child say by himself/herself *without* imitation or prompting? _____

What language(s) is/are spoken at home? _____
What is your child's primary language? _____

Does your child have any eating difficulties? YES NO If yes, please describe: _____

Does your child eat independently? YES NO
When did your child begin self-feeding? _____

What diet is your child currently on? _____
What food does your child like and dislike? _____

Does your child have any diet restrictions? YES NO If yes, please list: _____

Does your child:

Drink from a bottle? YES NO Drink from a cup? YES NO Finger feed? YES NO

Use eating utensils (spoon, fork, knife, etc.)? YES NO

Please describe which ones he/she uses _____

Dress independently? YES NO Tie own shoes? YES NO Wash and dry hands by self? YES NO

Can your child manipulate fasteners? YES NO _____

Is your child toilet trained? YES NO If so, when? _____

Play with other children or prefer to play alone? _____

When playing alone, what does your child prefer to play with? _____

What activities does your child prefer? _____

Describe your child's sleep patterns: _____

Rock back and forth? YES NO Difficulty with transitions? YES NO

Ignore when someone is talking to him/her? YES NO Exhibit temper tantrums? YES NO

Stare at objects or self in mirror for long periods of time? YES NO Spin objects? YES NO

Have strong preferences or dislikes for certain food (temperature, shape, color, texture)? YES NO

If yes, please explain: _____

Exhibit any unusual play? _____

Please describe your child's activity level (overactive, underactive) _____

Educational History

School: _____ Phone (____) _____ - _____

Teacher: _____ Grade _____ Does your child like school? YES NO

Is your child doing well in school? YES NO

Does your child receive special services? YES NO If yes, please list: _____

Check academic areas of difficulties or concern:

Reading Conduct Completing work Math Physical Education Playground time

Please describe your child's organization of behavior and space with school-related activities



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AUTHORIZATION TO RELEASE INFORMATION TO/FROM SPECTRUM THERAPY SERVICES

Concerning: _____
Name of the Child

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information for payments or administrative operations or as it relates to treatment.

I understand that I have the right to know at all times what information is shared regarding myself or my child. I understand that the identity of the designated parties must be verified before the release of my information. I know that I have the right to revoke this authorization at any time in writing.

1) **Name:** _____ **Relationship:** _____

Purpose: _____

Address to which information is sent: _____

Type of information released: _____

2) **Name:** _____ **Relationship:** _____

Purpose: _____

Address to which information is sent: _____

Type of information released: _____

3) **Name:** _____ **Relationship:** _____

Purpose: _____

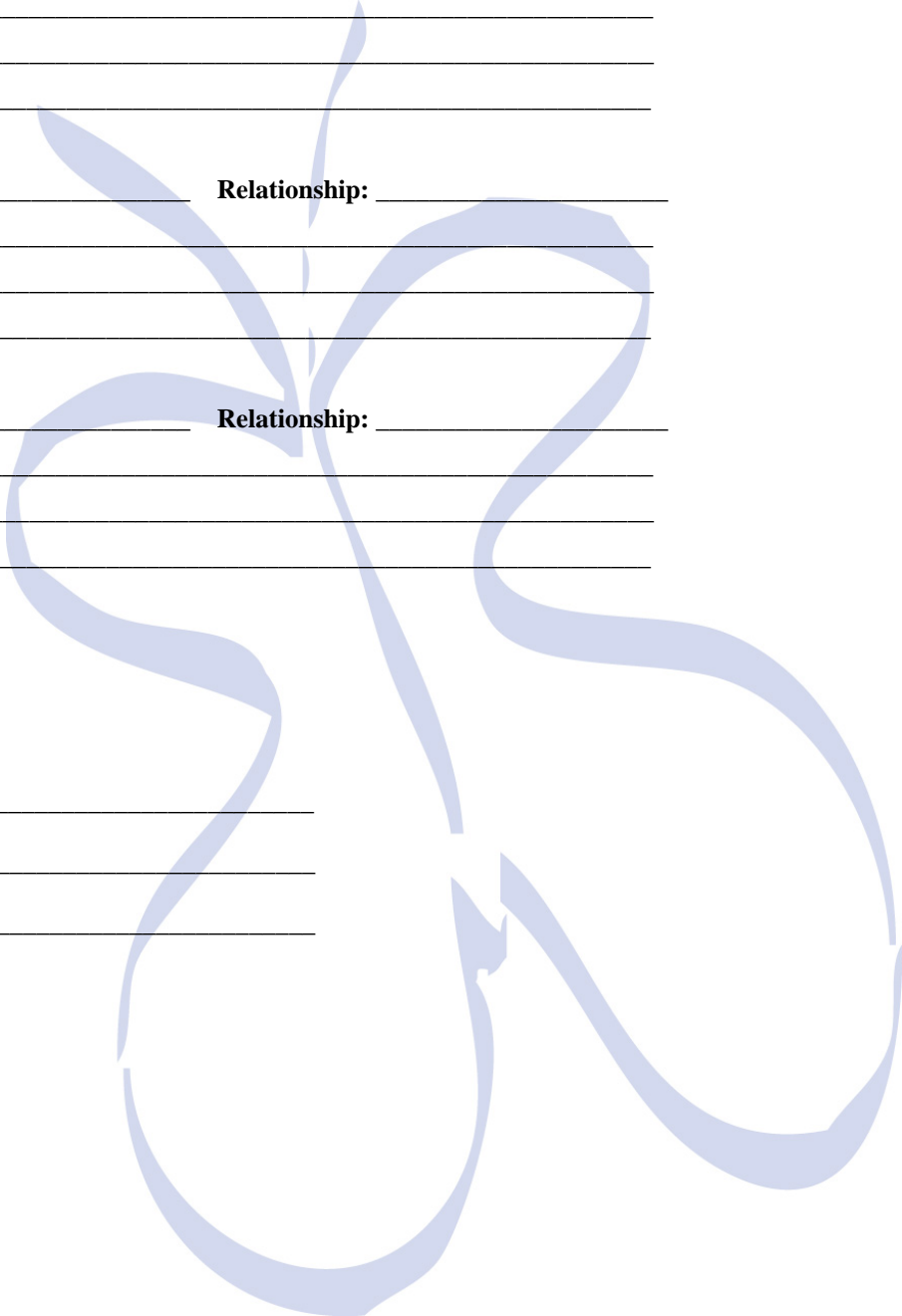
Address to which information is sent: _____

Type of information released: _____

Parent Signature: _____

Parent Print Name: _____

Expiration Date: _____





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POLICY STATEMENT

In an effort to avoid misunderstandings, this information sheet explains our business policies effective 04/01/04. We require that this form be signed and returned to us to indicate that you understand and accept our policies. You will also be given a copy for your records (copy provided in information package).

Evaluations May be paid 50% at 1st appointment, balance will be paid during parent conference, usually a week later.

EVALUATION SERVICE	PRICE
OT/PT SCREENING	\$150.00
Developmental Evaluations (Infants) 0-3	\$200.00
Developmental Evaluation Clinic Based 3 and older	\$250.00
Sensory Integration Praxis Test (SIPT)	\$500.00
Oral Motor/feeding Evaluation	\$300.00
Private School Site Evaluation	\$450.00

TREATMENT INDIVIDUAL THERAPY	PRICE
Private Pay Individual Clinic based Therapy per 60 minutes	\$125.00*
Private Pay Individual Clinic based Therapy per 30 minutes	\$62.50*
Private Pay Group School based Therapy per 60 minutes	\$30 per child (5 child minimum)*
Therapy, Feeding, Oral Motor 60 minutes	\$135.00*
Therapy, School Site/ Home 60 minutes	\$150.00*

**Please ask us about additional discounts.*

Therapy treatments are provided by licensed occupational therapists, physical therapists and speech-language pathologists with specialized training in pediatrics.

Discounts may apply at the time of visit only.

Accounts must have zero balance to qualify for a 20% discount.

Re-evaluation Progress Summaries are performed during treatment sessions semi-annually to insure that each child is benefiting maximally from therapy. Re-evaluations, with written reports, are charged a treatment charge. If other more extensive re-evaluations are necessary, this will be discussed with parents prior to the evaluation. Chart review and Insurance Letters of medical necessity are charged by the hour at the regular treatment rate (usually 1 hour).

Parent/ Guardian Signature

Date

ATTENDANCE POLICY

Spectrum Therapy Services wants to provide you and your child with the highest quality of therapy service offered by our interdisciplinary highly trained therapists.

One of the most important aspects of the success in our treatment is consistent attendance to therapy sessions. In order to meet the child's and family's needs, regular attendance is necessary. At *Spectrum Therapy Services* we understand there are sometimes circumstances that are unpreventable, thus, we are sensitive to them and we will accommodate for that. However, if poor attendance to therapy sessions are frequent and unspecified, *Spectrum Therapy Services* will not guaranty that your child's treatment needs can be met. If tardiness/lateness is too explicit *Spectrum Therapy Services* has the right to remove your child from the regular schedule and put him/her on a waiting list.

This policy has two major purposes

- 1) To provide your child with the best therapy sessions to achieve treatment goals.
- 2) To provide equal opportunity for children on the waiting list to be seen on a regular basis.

PLEASE READ CAREFULLY

- **Children must attend 75% of the monthly scheduled therapy sessions**
- **Two "No Shows" in one month constitute a reason for discharge from therapy and automatic placement on *Spectrum Therapy Services*' waiting list**
- **Last minute cancellations will be considered a "no show"**
- **Cancellations must be made 24 hours in advance to avoid charge**
- **Cancellations made less than 24 hours in advance will be subject to a \$25.00 cancellation fee**
- **Due to reduced space and HIPAA regulations, siblings and friends of your child are NOT allowed during treatment sessions. Only one parent or companion is allowed during treatment if desired**

Parent/ Guardian Signature

Date

Thank you for your understanding and we look forward to working with you and your child.



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CANCELLATION LATE FEES & SERVICE CHARGES

Specific time is reserved for you when you schedule an appointment. If you can not keep your scheduled appointment, please give us at least 48 hours advance notice, or notice by 6:00 am in case of child's illness, so that we may re-schedule your appointment and offer the reserved time to another patient. You will also avoid incurring a "cancellation", "same day cancellation" charge of \$25.00 or "no show" charge at the full treatment rate. Limit of 3 excused absences due to illness are allowed at no charge each 12 month period. After 3 absences due to illness, parents must provide a doctor's note to avoid regular cancellation charge being assessed.

Frequent cancellations may result in loss of regularly scheduled appointment time.

Accounts delinquent past 90 days will be subject to an 18% finance charge. A \$10.00 late charge will be added for each month that a payment has not been received. Returned checks are subject to a \$25.00 service charge.

INSURANCE COMPANIES

While most insurance policies do cover occupational therapy or physical therapy, this office makes no representation that yours does. Insurance policies differ greatly in the deductible amounts and the percentage of coverage for occupational, speech and physical therapy services. It must be understood that your insurance contract is between **YOU** and **YOUR INSURANCE COMPANY**, and you are fully responsible to us for the total amount charged.

BILLING SURCHARGES FOR INSURANCE AUTHORIZATIONS/VERIFICATION OF BENEFITS.

We are not able to obtain insurance authorizations or process insurance claims for evaluations only.

For treatment sessions, you have the option of having our office verify your benefits, obtain pre-authorization with your Insurance Company and submit your claims, if authorized. A \$50.00 surcharge per authorization will need to be paid by you at the time of the 1st appointment and/or at the time of authorization of benefits for treatment (benefit reauthorizations/extensions, etc). Authorization must be obtained prior to your first treatment appointment.

MEDICAID

Spectrum Therapy Services is a Medicaid provider. Each month a Medicaid status check will be performed to confirm eligibility. If Medicaid denies eligibility, guardians/ parents will be responsible for any future visit payments at regular price until conflict is resolved.

PAYMENT

We accept Visa and MasterCard as well as checks, money orders and cash.

Parent signature required:

I understand that I am financially responsible for payment in full of my child's account. I have read, understand and accept the office policies described in these forms.

Child's name

Date

Parent or Guardian signature

Parent or Guardian printed name



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NOTICE OF PATIENT INFORMATION PRACTICES

Please read this notice carefully. It contains information about how medical information about you or your child may be used or disclosed and how you may obtain access to information.

SPECTRUM THERAPY SERVICES LEGAL DUTY

Spectrum Therapy Services is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Spectrum Therapy Services uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, *Spectrum Therapy Services* may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefit that could be of interest to you.

Spectrum Therapy Services may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, *Spectrum Therapy Service's* policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information, you may revoke that authorization to stop future disclosures at any time, for any reason.

Spectrum Therapy Services may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. You may also request an updated copy of our new Notice of Information Practices at any time.

PATIENT INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when requested by law or in emergency circumstances. *Spectrum Therapy Services* will consider all such request on a case-by-case basis, but *Spectrum Therapy Services* is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that *Spectrum Therapy Services* may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact the HIPAA Hotline at 1-866-627-7748.

Parent's Signature

Date



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VIDEO AND PHOTO RELEASE

I, _____, release all rights to **Spectrum Therapy Services** of photographs or videos taking of my son, daughter, or child under my care for the purposes of professional advancement, promotion and advertising.

From this day forward, I relinquish all rights to claim any reimbursement of these photographs.

Signed: _____

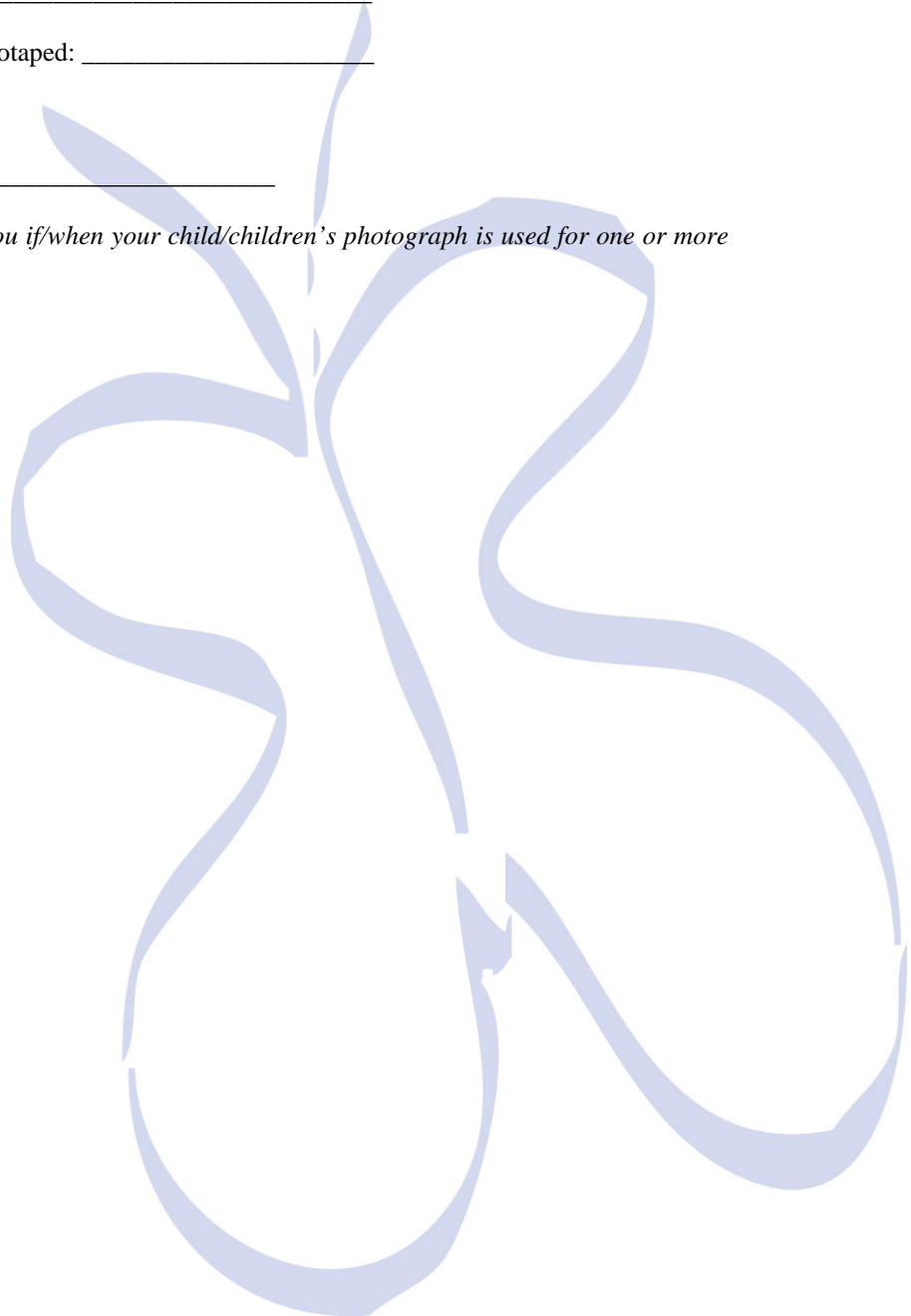
Print named signed above: _____

Relationship to the person photographed or videotaped: _____

Today's Date: ____/____/____

Witness: _____

Spectrum Therapy Services' staff will advise you if/when your child/children's photograph is used for one or more purposes detailed above.





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Dear Parents,

Our facility wants to meet the highest standards in regards to HIPPA COMPLIANCE. We do have a concern about respecting your confidentiality as a patient at Spectrum Therapy Services. As you know, after each session our skilled therapists' discuss to you about what happened during the appointment and/or recommend effective strategies that may be applied at home. Some of the information exchanged may be heard by other people in the waiting room.

As a result we want to make sure that is ok to discuss with you about your child, potentially in front of other people.

*If you do not mind talking about your child in the waiting room and want to continue to do so please write your name, sign and date.

Name: _____

Signature: _____

Date: _____

OR:

*If you do not want to talk about your child in the waiting room where other people may overhear your conversation, we respect your decision and will accommodate your needs. Please write your name, sign and date here if you want to discuss your child in a private area at Spectrum Therapy Services.

Name: _____

Signature: _____

Date: _____

