PATIENT REGISTRATION FORM

Patient Name:	Date of Birth:
Parent or Guardian Name:	
Address:	City: State: Zip Code:
Home Telephone:	Cell Phone:
Email:	
Patient's Doctor:	Doctor's Telephone:
Practice/Facility:	

Does your child have Medicare Part B? YES or NO (please circle one)

Insurance Information

Primary Insurance:	
Policy#: Sponsor SS# (Tricare only):	Group#:
Name of Policy Holder:	Relationship to Patient:
Secondary Insurance:	
Policy#: SS#:	Group#:
Name of Policy Holder:	Relationship to Patient:

Developmental Case History

Child's Name_____**Age**: ___ **Date of Birth: _____**_____

Parent(s)/Guardian Name_____

Referral Information:
How did you hear about us: _____?

Areas of Concern:	**Check all that apply**
Speech/Language	
Gross Motor	
Fine Motor	
Visual Perceptual	
Visual Motor	
Sensory	
Behavioral	
Eating/Feeding	
Learning Difficulties	
Handwriting	
Other:	

What would you like to see us work on with your child?
_____

Name of pre-school, daycare, or school: _____

Developmental History:
List the age when your child began: Crawling_____Walking_____ First Words _____ Combining words_____
Did your child babble as an infant? Yes or No

Family History:
Please check all that apply.

	Maternal	Paternal
Speech Problems		
Stuttering		
Learning Disability		
Hyperactivity/Attention Problems		
Mental Retardation		
Emotional Problems/Depression		
Birth Defects		
Seizures		

Birth History:
Any complications during pregnancy? Yes No _____

Any complications immediately following birth? Yes No_____

Gestational Time: _____ Birth Weight: _____

Medical History:
Is your child current with his/her immunizations? Yes or No
Is your child taking any regular medications? Yes or No
If yes, what medications? _____
Has your child been hospitalized for any reason? Yes No _____

Has your child had frequent ear infections? Yes or No
Does your child have/has your child had tubes? Yes or No When? _____

Does your child have any other illness/medical problems?_____

Please list important or primary medical history or diagnosis:
_____

Feeding/Eating History:
Did your child have any difficulties feeding after birth? If so, please explain_____

Is your child a picky eater? Yes or No
_____

When did your child stop using a bottle?_____
Pacifier?_____

Play/Social Information:
Does your child play appropriately with toys? Yes or No
_____

Does your child engage in any odd behaviors? Yes or No
_____

Does your child have difficulty attending or concentrating? Yes or No

Does your child have any significant problems with behavior? Yes or No

Sensory/Motor Development:
Does your child appear awkward or clumsy? Yes or No

Does your child seem to dislike certain type of textures (does not like getting dressed, dislikes tags in clothes, does not like water)? Yes or No

Please list dates and types of any other evaluations
(example: neurologist, early intervention, occupational therapy, etc.) and **where**?
_____

Insurance Agreement

Dear Parents,

Thank you for choosing THERAPLAY PLLC. as your pediatric speech-language and occupational therapy provider. We strive to provide services that are professional, comprehensive and with excellence to all children in need of our services. For this reason, we want to ensure that all of your children's insurance services are accurate and up to date.

We will be responsible for billing your insurance provider for services rendered; however, depending on your policy, deductibles and/or co-pays will need to be met before your provider will agree to make payments.

You, as the policy holder, are also responsible for letting us know of any changes in insurance and paying any deductibles and/or co-pays that may apply. In addition, if your insurance provider denies any claims, you as the parent or guardian will be responsible for payment of these services rendered. Any payments, in which you as the parent or guardian are responsible for, will be billed to you on a weekly basis. If you fail to make payments, your child's services will be put on hold until payments are received, and your account is paid in full.

If your insurance provider is **Medicaid**, benefits will cover 100% of the payment for the evaluation and therapy. This cost is only covered if your child remains eligible for services.

If you receive disability benefits for 24 consecutive months, you become eligible for Medicare. We do not accept Medicare. It is your responsibility to inform us if you become eligible for Medicare.

We ask that all parents let THERAPLAY PLLC. know when there is a change in your insurance provider, including changes from one Medicaid prepaid health plan (PHP) to another.

As the parent or guardian, I have read the above information and understand THERAPLAY PLLC'S Insurance Agreement. I accept all terms and conditions.

_____ _____

Parent/Guardians' Name Date

_____

Parent/Guardian's Signature

Patient Notification of Privacy Policies

THIS NOTICE DESCRIBES HOW YOUR MEDICAL RECORDS MAY BE USED OR DISCLOSED AND HOW YOU CAN ACCESS YOUR RECORDS. PLEASE REVIEW IT CAREFULLY.

I hereby authorize use or disclosure of protected health information about my child as described below:

1. Confidential information is stored in a secure location away from public access. All computers containing confidential information are only accessed by password.
2. THERAPLAY is authorized to disclose pertinent health information to insurance companies or referring physicians for the purposes of requesting doctor's orders, authorization for service or to obtain reimbursement for services. Information may be sent via first class mail or fax with procedures in place to limit the likelihood of unauthorized access.
3. THERAPLAY and its employees are authorized to use or disclose pertinent health information that is required for speech-language therapy purposes.
4. THERAPLAY may disclose protected health information considered pertinent to Speech-language therapy to specified professionals (i.e. social workers, teachers, psychologists, physicians, therapists, etc.) with a signed release form from the parent or guardian.
5. I, the parent/guardian, may revoke this authorization by notifying THERAPLAY in writing of my desire to revoke it. However, I understand that any action already completed prior to the request to revoke this authorization cannot be reversed, and my revocation will not affect those actions.
6. This authorization expires when the client is discharged from therapy, although the Company will always use professional discretion when sharing any public health information.

I, _____ (parent/guardian name):

- ☐ understand and agree that Theraplay uses video recording for therapy and parent education purposes. These recordings will not be used for any other purposes.
- ☐ Consent to my child's image being used for marketing purposes

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian's Printed Name Child's Name

*If you have any questions or concerns, please feel free to contact our Privacy Officer, Jeanine Morton at: (919) 774-1281.

Guidelines and Policies

Dear Parents,
The policies written below are designed to improve our ability to see all of our clients and to provide complete and consistent treatment for your child. We hope that these policies will improve our overall service to you. Since continuity of care is important to maximize the outcomes of your child's therapy, we use the following guidelines for your appointments:

The Therapy Time

Your child is scheduled for a 30 or 60 minute therapy session with our staff. The last few minutes of each session is used to discuss progress and current needs related to your child. We welcome your feedback on each session so that we may continuously enhance the effectiveness of their program.
We ask that you:

- Arrive on time. You (the parent or caregiver) must be present in the waiting room during the last 5 minutes of the session to discuss your child's session and any homework.
- Please make sure that we have your current contact information if you leave the building in the event of an emergency or need to be reached.
- If you bring a sibling, they are not allowed on any equipment used for therapy purposes because of liability issues. Please keep them under supervision in the waiting room. We have provided toys/books to entertain the siblings during this time. Please help us keep the area safe and tidy.
- Please refrain from eating food and drinks as much as possible in our waiting room. Water and dry snacks only are allowed in the waiting room. Also, please **NO PEANUT** or **NUT** products in the waiting room due to potential allergies of other clients.
- You will be financially responsible for any damage by your child to any therapy/office item. Payment for items is required prior to (or at) your child's next therapy session.
- Copays are due at the time of service

Inclement Weather/School Holidays or Closings

Please follow our Facebook page, **Theraplay, PLLC.** for closings/delayed opening information. We are open on the following Federal holidays: MLK Jr. Day, Presidents Day, Good Friday, Easter Monday, and Juneteenth.
In the event of inclement weather, we will be contacting you directly to either provide teletherapy information or find a time within the same week to reschedule.

Non-Emergency Cancellations: at least 24 Hours Notice

This includes vacations, pre-planned doctor's appointments, family events, parties, sporting events, lack of babysitter, etc. This includes anything not designated "emergency". The session must be cancelled with at least 24 hours notice. **If cancellations become excessive for non-emergency purposes, then the child may lose his/her weekly slot in the therapy schedule.**

If you are going to be late for a scheduled appointment, please call and let us know. If you are more than 15 minutes late for a Speech therapy appointment, the appointment may be cancelled by the therapist. If you are 15-29 minutes late for an Occupational therapy appointment, the appointment may be cancelled by the therapist. If you are seen, your session will end at the regularly scheduled time. If you are more than 30 minutes late for an occupational therapy session, the appointment will be cancelled.

No Show/Late Cancellation Policy

A no show is considered as a missed visit (no show/no call) or a late cancellation (**less than 24 hours notice).** If the child has missed 50% of their visits due to no shows or late cancellations in a month, it will result in your child being removed from their therapy slot and placed on the waiting list. If you have removed more than once, you will be discharged.

Sick Child Guidelines:

We want our clients to be productive in therapy as much as possible. In order to help keep all our clients and staff healthy and well, please keep in mind these guidelines to assist in making the decision to keep your child home from therapy.

- If your child is too ill to attend school or daycare, their therapy appointment should be cancelled. Please call at least 2 hours prior to your child's appointment.
- If your child was sent home sick from school, their therapy appointment should be cancelled.
- If your child woke up with a fever (even if you gave them fever reducing medication and they no longer have a temperature at the time of their appointment), their appointment should be cancelled.
- If your child has a runny nose, coughing or sneezing, their appointment should be cancelled.
- If your child has had diarrhea or has vomited, he/she must stay home for 24 hours after the episode.
- If your child has been diagnosed with hand, foot, mouth disease, he/she must be fever free for 24 hours and not have any open and/or oozing blisters.
- If your child has pink eye, he/she must be on medication for 48 hours prior to returning to therapy.
- If your child has a rash of unknown cause, please check with your physician before returning to therapy.
- If lice are found on your child, he/she must not return until 24 hours after the first treatment of a product such as Rid or Nix.
- If your child has chicken pox, they must stay home a minimum 7 days after the first appearance. The crust must be dry.

Patient's Name: _____

Parent/Guardian Signature: _____ **Date:** _____