NEW PATIENT INTAKE INFORMATION
****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(s): _____

Biological: ☐ Adoptive: ☐ Adoption Date: _____ Foster History: _____

Age: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip code_____

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

Parent Email: _____

INSURANCE
*****IF PRIVATE PAY, DO NOT FILL OUT (NO CARDS NEEDED)*****

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

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

Policy #: _____

Circle Type of Medicaid: Medicaid FFS/TEFRA ☐ SC Solutions ☐ ***Absolute Total Care*** ☐ ***BlueChoice*** ☐

Medicaid Policy #(s): _____

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

Patient Name: _____ **DOB:** _____

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

I. 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 your child has had and the reason/outcome: (use back of form if necessary)
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 last screening? _____

Please explain: _____

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

Please explain: _____

II. 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: _____

If yes, where 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: _____

III. DEVELOPMENTAL HISTORY – answer those 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 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: _____

Patient Name: _____ **DOB:** _____

Concerns/Special Notes re: Speech/Language:_____

Gross Motor Development (check all that apply)

Did/does your child:

☐ Lift head while on stomach
☐ Roll over
☐ Throw a ball
☐ Jump
☐ bear weight on legs
☐ stand holding on
☐ run
☐ walk up/down steps
☐ bear weight on arms
☐ stand alone

Concerns/Special Notes re: Gross Motor: _____

Fine Motor Development (check all that apply)

Did/does your child:

☐ Hold objects in hand
☐ Draw
☐ reach for objects
☐ pick up small objects
☐ clap hands
☐ manipulate fasteners
☐L ☐R hand preference
☐ point at objects

Concerns/Special Notes re: Fine Motor: _____

Sensory (check all that apply)

Did/does your child:

☐ Have trouble falling asleep
☐ engage in self-stimulating behaviors
☐ react negatively to "normal" noises
☐ fall frequently/clumsy
☐ dislike certain temperatures/textures
☐ picky eater
☐ bites/mouths things
☐ seeks spinning
☐ avoid being touched
☐ hear things most people tune out
☐ refuse to wear certain clothing/bothered by shirt tags or sock seams
☐ is always in motion
☐ toe walks
☐ covers ears
☐ dislikes haircuts/nail trimming
☐ constantly talks/hums

Concerns/Special Notes re: Sensory: _____

IV. 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 your child (toys, songs, peers, books, etc):_____

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:

Treatment Consent / 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 consent to my child being treated at The Therapy Place and 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/Caregiver Signature Date:

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

ASSIGNMENT OF INSURANCE BENEFITS

******IF PRIVATE PAY, DO NOT FILL OUT******

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

FINANCIAL POLICY

The Therapy Place is a Medicaid facility accepting SC Solutions, Absolute Total Care, 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.

If your child does not have Medicaid (or one we do not accept), payment is expected in full, at the time service is rendered***. 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)

The Therapy Place accepts cash, check, or credit card.

Returned Checks:
A $35.00 service fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to pre-pay all future services in cash or credit card.

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

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

Patient Billing Contract
FOR THOSE WITH PRIVATE INSURANCE AND MEDICAID

****SKIP IF YOUR CHILD HAS MEDICAID ONLY****

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.

_____ (initals) 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 Dawn or Terry 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.

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

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 policy. Consistency and regular attendance is the key to making your child's therapy a success.

- **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.
- **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. We do realize that is not always possible and will take extenuating circumstances into consideration.

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

- **Tardiness:** Children arriving up to 15 minutes late to therapy will be treated for the remainder of the time. However, if your child is more than 15 minutes late to therapy it may be considered an absence.
- **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.
- **Therapist/Center Cancellations:** Your therapist will call you as soon as possible to inform you of a cancellation. Attempts will be made to reschedule if possible. Treatment sessions cancelled by your therapist will not count against your attendance percentage.
-

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

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

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

CONSENT FOR USE, DISCLOSURE AND/OR RELEASE OF PERSONAL AND HEALTH INFORMATION

Patient name: _____ Date of birth: _____
Address: _____ City: _____State: _____Zip_____
Home Phone #: (____)_____Parent Cell Phone: (____)_____

Parent/Guardian Name: _____***Printed Please***

Written and Verbal Communication Release To:
Agency Name: ***The Therapy Place Inc*** Phone #: ***803-787-3033***
Address: ***3620 Covenant Road*** City: ***Columbia*** State: ***SC*** Zip: ***29204***
Fax #: ***803-787-0300***
If Agency, contact name and title: _____ _____

Written and Verbal Communication Release From:

Agency Name: _____Phone#: (____)_____
Address: _____City: _____ State: ____Zip: _____
Fax #: (_____)_____
If Agency, contact name and title: _____

Information to be released:

☐ Medical Records ☐ Therapy Records ☐ Developmental Records
☐ Educational Records ☐ Personal Family Information Other: _____

A copy of this consent form will be as good as the original. Upon verbal request, I may have a copy of this consent form and I may revoke this release at any time upon written request.

Parent/Guardian Signature: _____
Printed Name: _____
Date: _____ This authorization is good for 3 years from date or until revoked

** Alternate Expiration Date: _____ ** ☐ Good for one time only

Office Use Only:
_____
_____
_____

We are very excited to continue to be opened for in person therapies! In saying that, and making changes adhering to CDC and DHEC regulations, the clinic and schedule will be different than prior to this pandemic. We continue to offer both in person and teletherapy as long as allowed. Here are our safety measures that we ask you to follow and we as a staff will also adhere.

- Please stay home if your child or anyone in the household is sick, if you have been exposed to anyone with Covid-19 or if you suspect any illness in your family. We refer to current DHEC guidelines for specific timelines. Doing so will protect our staff, other children, and help prevent future closures.
- **When arriving at the clinic please stay in your vehicle.** Staff will be watching for your arrival and will come out to greet you. Your child's temperature will be taken while in the car. If your child has a temperature of 100 degrees or higher, he/she will not be allowed to attend the session that day. Children must be fever-free for at least 48 hours (or longer if determined by their physician or other health authority) prior to returning for therapy.
- Therapists and staff will all be wearing PPE as appropriate for the nature of the visit, which may include gloves, masks, face shields and over-sized shirts. PPE will be changed between each child's visit.
- At the end of your child's session, please stay in your vehicle until we bring your child to you. If your child requires your assistance to get in the car or buckle up, please wear a mask when you exit your vehicle as we will not be able to maintain appropriate social distancing during hand-off.

For your peace of mind:

- When in the clinic, your child will be kept to specific areas to assist in social distancing. A maximum of 2 children/therapists will be present in the gym at any one time and they will remain at opposite sides of the gym.
- If your child has a tendency to drool please bring extra shirts and/or bibs so that the therapist can change your child during their session if necessary. Dirty clothes will be placed in a bag and returned to you at the end of the session. If your child has a runny nose please contact your child's therapist prior to scheduling to discuss further.
- If your child is not yet potty- trained, please bring needed items (diaper/pull up/wipes) to therapy and give to therapist so they will be able to change them to limit amount of people in building.
- We will not be allowing anyone in waiting room and/or back with patients unless deemed necessary. Any adults in the building will need to wear a mask. Talk with your individual therapists to discuss if you have concerns.

These protocols may change as we continue, but we will let you know as soon as they do. Please let us know if you have any concerns or suggestions. We acknowledge that these protocols are meant to deter/decrease the risk of exposure but we cannot guarantee that your family will not come into contact with COVID. By signing below you assume this risk and understand that we are doing all we can to prevent it from happening.

Thank you, TTP Staff

Parent Signature: _____ Date: _____

Print Parent Name: _____ Child's Name: _____