CREC | Expert Solutions

CHILDREN'S THERAPY SPECIALISTS
Clincial Services

INTAKE INFORMATION Date _____

Client Information

Client Name _____ Date of Birth _____ Gender M F
Address _____ City _____ State _____ Zip _____
School _____ Grade _____ Teacher _____
Parent's Name _____
Email _____ Do you check this regularly? Y N
Phone day _____ evening _____ cell _____

Diagnosis _____ Precautions (e.g., glasses, seizures, safety)_____
Any known allergies (e.g., food, latex) _____
How did you hear about us? Dr. ____ Website ____ Friend ____ Phonebook ____ Ad ____ Other _____

Insurance

Primary Insured's Name _____ Relation to client _____
Insurance Plan _____ Is there another health benefit plan? Y N
Insured's ID # _____ Insured's Policy Group or FECA # _____
Insured's Date of Birth _____ Gender M F Employer's Name _____
Insured's Address _____ City _____ State _____ Zip _____

Secondary Insured's Name _____ Relation to client _____
Insurance Plan _____
Insured's ID # _____ Insured's Policy Group or FECA # _____
Insured's Date of Birth _____ Gender M F Employer's Name _____
Insured's Address _____ City _____ State _____ Zip _____

Primary Physician

Physician's Name _____
Practice Name _____
Address _____ City _____ State _____ Zip _____
Phone _____ Fax _____

Authorizations & Acknowledgments

Notice of Privacy

I hereby acknowledge that I have received a copy of CREC's Notice of Privacy and that I may request a copy of any amended Notice of Privacy.

Client Name (printed) _____

Signature _____ Date _____

Parent/Legal Guardian

Printed Name _____

If not signed by client, please complete below:

Relationship to client:

❑ parent ❑ legal guardian ❑ conservator ❑ client's representative

Insured's or Authorized Person' Signature

I authorize payment of medical benefits to the undersigned physician or supplier for services described on the health insurance claim form.

Client Name (printed) _____

Signature _____ Date _____

Parent/Legal Guardian

Records Release

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature _____ Date _____

Parent/Legal Guardian

Scheduling

Please list all times your child would be available for their appointment(s). Some times are more difficult to schedule than others. It will assist us with scheduling your child quicker if you give us as many options as possible. We will do everything we can to work with you. Thank you for your assistance.
Monday – Friday (days and evenings)
Saturday (mornings)

CLINIC COPY

CTS Policies and Fees

Thank you for your interest in our services. As a children's therapy clinic, our goal is to provide high quality services that are helpful to the child/client and their family.

Evaluation/Intervention/Consultation/Education

We offer the following services to meet the needs of our clients and their families:

1. Initial Evaluation (one session)* — $240.00
   - Treatment Plan*

2. Comprehensive Evaluation** — $695.00
   - Short Summary Paragraph (one page) & Family Consultation
   - Narrative report** (test interpretation relevant to daily interactions)
   - Accommodations & modifications for home and/or school

3. The Sensory Integration and Praxis Test (SIPT)** — $1300.00
   A specialty evaluation designed to help identify difficulties in the various areas of sensory functioning in 4-8.11 year olds. Includes the following:
   - Test administration (2-3 testing sessions)
   - Test interpretation & written report
   - A one-hour follow up visit to discuss results

4. The Listening Program® (TLP)**
   The TLP is designed to help children & adults with auditory perceptual/processing concerns often associated with ineffective listening, learning and communication skills.
   Includes the following:
   - Materials (Headphones & CD's) — $350.00 to $500.00
   - An initial consultation — $130.00
   - Follow-up consultation (30 min/month) — $65.00

5. Consults by special request ** — $32.50 per 15 min
   - Consults to schools
   - Review of reports
   - E-mail correspondence
   - Phone consultation

6. Therapy Sessions (based on 1 hour) — $130.00

7. Workshops & Training –ask us about hosting a workshop or training in your area

* Often covered by insurance less applicable co-pay
** Often NOT covered by insurance; an out-of-pocket expense

Financial

Anthem/ Aetna/ United Healthcare Insurance

1. I understand that if Children's Therapy Specialists (CTS) is a recognized provider for my insurance company then they may bill my insurance company directly per my request. I am responsible for providing current insurance information to the CTS billing office. This includes the following:
   - Prior authorization based on my insurance policy
   - Letter of medical necessity from the client's primary care physician
   - Referral from primary care physician
   - A copy of your current insurance card
   - Insurance claim form completed and signed by the client for first submission
2. Should my claim be denied in part or full by my insurance company, CTS will bill me for services not covered.
3. I understand that, if applicable, I am responsible for paying my insurance plan's co-payment/co-insurance at the time of the treatment visit.

4. I understand that I may submit claims to my insurance company and that CTS will provide a monthly billing statement, which includes all of the necessary information for submission (e.g., client information, diagnosis codes, procedure codes, dates of service, service provider, and CTS's tax identification number).

Self-pay

5. I understand that payment is due at the time of service. Checks should be made payable to Children's Therapy Specialists or CTS.
6. At my convenience, I can set up automatic billing on my MasterCard or VISA for services provided. Credit card authorization forms are available from the CTS billing office.
7. Full payment is due for all services provided prior to the release of any written reports.

General

8. I understand that a 1 hour treatment session typically consists of 55 minutes of active participation by the therapist and the client/family. This time allows for 1:1 treatment time with the child and therapist, as well as, 1:1 consultation time with the child, therapist, and family to promote carry over of intervention strategies beyond the scope of the treatment session.
9. If I leave the building during my child's therapy session, I will provide a phone number in case of emergency and will be available during the last 15-minutes of the session for consultation and planning.
10. If additional time is needed for consultation, I can schedule a meeting or phone consultation with the therapist. In-depth phone consultations (i.e., greater than 10 minutes) may be billed to my account at 15-minute intervals.
11. I understand that once my weekly treatment appointment schedule has been determined, CTS is often unable to accommodate changes on a temporary basis. When a permanent change in time is needed, I must give as much advance notice as possible for the Clinic to attempt to accommodate this request. A change may necessitate a change in therapist as well. When a therapist must initiate a permanent change of schedule, the therapist will give you at least a two-week notice and try to accommodate your needs.

Cancellations

12. Regular attendance is essential for my child's growth in therapy. I understand that should I need to cancel a session, a 24-hour advanced notice is recommended. In addition, I will make every attempt to reschedule missed sessions. Repeat cancellations may result in the loss of my regularly scheduled timeslot.
13. I am aware that CTS does NOT follow the school calendar regarding holidays and inclement weather. Appointments should be confirmed with the therapist or by calling CTS should any questions exist regarding the schedule.
14. I understand that if I do NOT call and do NOT show for a scheduled session, I will be charged a no show fee of $30.00. No Show fees will be due prior to scheduling any further appointments and are considered an out-of-pocket expense.
15. I understand that when the treating therapist is ill or on vacation, CTS will make every effort to provide a substitute therapist for continuity of service. In addition, CTS will make every effort to schedule the therapist at my regularly scheduled appointment time.
16. I understand that CTS requests notification of family vacations or obligations that impact scheduling at least two weeks prior to the expected absence.

Family

17. CTS staff acknowledge that siblings often need to accompany the child receiving therapy. During the treatment session, parents are responsible for watching, occupying (i.e., outside of clinic area), and cleaning up after siblings.
18. If the parent leaves the building, siblings CANNOT be left unattended at CTS.
19. In an effort to maintain a food allergy-free zone, we request that beverages or food items not be consumed in our waiting area. Thank you for your cooperation in this manner.

Acknowledgment of Risk

20. I acknowledge that there are some risks inherent in the use of the therapy equipment at CTS. I agree to indemnify and hold Children's Therapy Specialists harmless from any and all losses and claims for any injuries or other damages occurring to my child, personal belongings, or myself while using therapeutic equipment.

Policy and Fees

I acknowledge that I have read the policies and fees defined by CTS and agree to abide by them.

Client Name (printed) _____

Signature _____ Date _____

Parent/Legal Guardian

CLIENT HISTORY

Client/Family Concerns
1. Please identify the reason you are seeking services for your child.
2. List your main areas of concern.
3. List the goals you would like accomplished through our services.

Medical History
1. Please describe your child's birth history. List any complications during pregnancy, birth or infancy.
2. Does your child experience any of the following: Diarrhea ❑ Never ❑ Occasionally ❑ Frequently Stomachache ❑ Never ❑ Occasionally ❑ Frequently Vomiting ❑ Never ❑ Occasionally ❑ Frequently Headache ❑ Never ❑ Occasionally ❑ Frequently Constipation ❑ Never ❑ Occasionally ❑ Frequently Earache ❑ Never ❑ Occasionally ❑ Frequently
3. List any additional illnesses, injuries and hospitalizations your child has had. Include severity of illness and frequency.
4. List any medications that your child takes regularly.
5. Does your child have any known or suspected allergies? Please list.

Developmental History

1. When did your child first achieve the following motor milestones?

Milestone	Age	Comments
Crawling		
Sitting unassisted		
Walking		
Holding a cup		
Using a spoon		
Using crayons		
Toilet training		

2. Please describe any developmental challenges your child has faced or continues to face.

Daily Routines

1. Do you have concerns with your child's routines in the following areas?

		Yes	No	Comments
Mealtime	Ex: atypical appetite, limited diet, poor routines, challenging behaviors during mealtimes			
Dressing	Ex: refusal to wear certain clothing, lack of independence, challenging behaviors during dressing			
Bathing	Ex: genuine dislike for bathing, lack of independence, challenging behaviors during bathing			
Toileting	Ex: poor awareness of toileting needs, bedwetting, daytime bowel or bladder accidents, lack of independence			
Toothbrushing	Ex: challenging behaviors or lack of independence			
Hairbrushing	Ex: challenging behaviors or lack of independence			
Washing	Ex: challenging behaviors or lack of independence with washing hands & face			

2. Please comment on other concerns that you may have with your child's daily routines. This may include your child's sleep routines, transitions, homework, organization.

Prior Evaluations/Services

1. Has your child had any formal evaluations/testing? If yes, please list and include dates.

2. Please identify any of the following with whom you have had contact concerning your child. Please provide name and address.

- ❑ Psychologist _____
- ❑ Neurologist _____
- ❑ Physical Therapist _____
- ❑ Occupational Therapist _____
- ❑ Speech-Pathologist _____
- ❑ Special Educator _____

Other

An additional comments or concerns.

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