



63 Sarasota Center Blvd. #101, Sarasota, FL 34240

Phone: (941) 379-3725 Fax: (941) 377-1131

Dear Families:

Thank you for contacting us about providing a therapy evaluation for your child. Please find the enclosed information packet. After you have filled this out, please return it to our office so we may begin processing your application.

If we bill insurance for you, we will assist you by verifying your benefits with your insurance company. We also suggest you check with your insurance company to determine whether the Therapy your child needs is a covered service under your policy.

Once your application is complete, a Therapist will contact you to set an appointment. Should you have any questions in the meantime, please do not hesitate to contact us. We look forward to getting to know your family!

Best Regards,

The Staff of Children's Therapy Works



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Patient Information

Date: _____

Patient's Name: _____ DOB: _____

Address: _____

Home Phone: _____ Cell #: _____

Mother's Name: _____ Mother's Work Phone: _____

Father's Name: _____ Father's Work Phone: _____

Physician: _____ Physician's Phone: _____

Insurance Information

Insured's Name: _____ Insured's Employer: _____

Primary Insurance Co: _____ Insurance Phone: _____

Insurance ID# (from card): _____ Group #: _____

Type of Insurance (circle one): HMO PPO QPOS Other: _____

Secondary Insurance Co: _____ Insurance Phone: _____

Insurance ID# (from card): _____ Group #: _____

Medicaid Card#: _____

Client of CMS? _____ EIP? _____ Med-Waiver? _____

AUTHORIZED (INSURED) PERSON'S SIGNATURE: I authorize the release of medical or other information necessary to process insurance claims. I authorize payment of medical benefits to Children's Therapy Works, Inc.

Insured's Signature

Date

Insured's Social Security Number



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Patient Background Information

Name: _____ Date: _____

Birth Order: _____ Birth Weight: _____

Circle One: Premature Full Term Postmature

Describe if necessary: _____

Apgar Score at 1/5 Minutes: _____

Forceps / Vacuum / C-Section Yes or No: Describe: _____

Please Describe on Back if Necessary:

Any Complications: Illness / Infections / Stress During Pregnancy? Yes or No

Any Complications During Labor and Delivery? Yes or No

Difficulty Nursing and/or Bottle Feeding? Yes or No

History of Reflux? Yes or No Managing a Varied, Age Appropriate Diet? Yes or No

Developmental Milestones Please note approximate age at which he/she did the following:

Sat _____ Belly Crawled _____ Crawled _____ Cruised _____ Walked _____

Said First Words _____ Talked _____ Toilet Trained (Bladder) _____ (Bowel) _____

Undressed Self _____ Dressed Self _____ Managed Snaps, Zippers, Buttons _____

Tied Shoes _____ Started Pre-School _____

Preferred Hand? Left / Right Age Established? _____

Ear Infections? Yes / No (How many, at what ages?) _____

Allergies? Yes / No Describe: _____

Injuries? Hospitalizations? Yes / No Describe: _____

Seizures? Yes / No Describe: _____

Most Recent Eye Exam? Date: _____ Hearing Exam? Date: _____

Medications? List: _____



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CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____ to release information from
the records of _____.

The information is to be released to Children's Therapy Works, Inc. for the purpose of developing a Therapeutic Program for the above named client. The information to be released is marked below.

- _____ Medical History
- _____ Physical Therapy Evaluation, assessment and program plan
- _____ Occupational Therapy Evaluation, assessment and program plan
- _____ Speech Therapy Evaluation, assessment and program plan
- _____ Classroom Individual Educational Plan (I.E.P.)
- _____ Other: _____

Date: _____ Signature: _____
Parent or Guardian

Please send the indicated material to:

Children's Therapy Works
63 Sarasota Center Blvd., #101
Sarasota, FL 34240



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Name: _____ Date: _____

PARENT'S CONCERN LIST

Please indicate areas that are of concern for you or your child.

1. Mobility
2. Feeding
3. Fine Motor Skills
4. Gross Motor Skills
5. Speech
6. Developmental Progress
7. Attention
8. Play Skills
9. Self-esteem
10. Peer Interaction
11. Family adjustment
12. Learning rate

Please indicate any other areas of concern below:

1. _____
2. _____
3. _____

Name: _____

CHILDREN'S THERAPY WORKS FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your child's therapeutic needs. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete our "Information and Insurance" form before seeing the therapist.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH AND CHECKS.

WE WILL BILL MEDICAID, EIP, AND SOME INSURANCE COMPANIES WITH PRIOR APPROVAL.

WE OFFER EXTENDED PAYMENT PLAN WITH PRIOR APPROVAL.

Regarding Insurance

We may accept assignment of insurance benefits after your second visit. However, we do require anticipated deductible and co-pay of the bill to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information, a copy of your insurance card, and an original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits, we require that you be pre-approved on our extended payment plan. If your insurance company has not paid your account in full within 60 days, the balance will be automatically billed to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance.

Regarding Insurance Plans where we are a participating provider -- all co-pays and deductibles are due at time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge you for the missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments. Sudden onset of illness may be excused by your therapist.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to the Financial Policy.

X _____ Date: _____
Signature of Responsible Party



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Name: _____ Date: _____

SENSORY PROCESSING HISTORY

Please mark with a check (✓) those items that currently describe your child. Please mark with an asterisk (*) those items that previously described your child. Feel free to add items that you think are related so that they can be discussed with the therapist.

Thank you.

TACTILE

- | | |
|--|--|
| <input type="checkbox"/> dislikes having teeth brushed | <input type="checkbox"/> seems over-sensitive to unexpected touch |
| <input type="checkbox"/> dislikes dental visits | <input type="checkbox"/> avoids physical affection unless self-initiated |
| <input type="checkbox"/> dislikes wearing socks/shoes | <input type="checkbox"/> constantly seeks to touch people or things |
| <input type="checkbox"/> dislikes having face washed | <input type="checkbox"/> needs to hold objects in hand |
| <input type="checkbox"/> dislikes hair combing | <input type="checkbox"/> excessively mouth objects or chews clothes |
| <input type="checkbox"/> dislikes feeling of new clothes | <input type="checkbox"/> bangs head intentionally |
| <input type="checkbox"/> wants tags in clothes cut out | <input type="checkbox"/> overreact to getting hurt |
| <input type="checkbox"/> dislikes having feet touched | <input type="checkbox"/> under-react to getting hurt |
| <input type="checkbox"/> dislikes having hand held | <input type="checkbox"/> becomes impatient/disruptive standing in line |
| <input type="checkbox"/> dislikes seams in clothing/socks | <input type="checkbox"/> seem excessively ticklish |
| <input type="checkbox"/> has strong clothing preferences | <input type="checkbox"/> frequently bumps/pushes/fights with others |
| <input type="checkbox"/> dislikes elastic in sleeves/waist | <input type="checkbox"/> dislikes long sleeves, high necklines |
| <input type="checkbox"/> dislikes wearing shorts/bathing suit | <input type="checkbox"/> over or under dress for temperature |
| <input type="checkbox"/> dislikes playing with messy materials | <input type="checkbox"/> dislikes baths or showers |
| <input type="checkbox"/> other (describe) _____ | |

VISUAL

- | | |
|---|---|
| <input type="checkbox"/> has a diagnosed visual problem | <input type="checkbox"/> avoids eye contact |
| <input type="checkbox"/> appears sensitive to light | <input type="checkbox"/> loses place while reading or copying |
| <input type="checkbox"/> excessively blinks, squints, rubs eyes | <input type="checkbox"/> gets easily distracted by vis. stimulation |
| <input type="checkbox"/> short attention for visual activities | |

Date of last vision exam: _____

SENSORY PROCESSING HISTORY (cont.)

OLAFATORY AND GUSTATORY

- | | |
|--|---|
| <input type="checkbox"/> unaware of flavors, taste | <input type="checkbox"/> over-sensitive to taste, flavors |
| <input type="checkbox"/> eat a limited variety of foods | <input type="checkbox"/> over-sensitive to temperature |
| <input type="checkbox"/> explores objects first by smell | <input type="checkbox"/> over-sensitive to smells |
| <input type="checkbox"/> difficulty recognizing odors | <input type="checkbox"/> reacts negatively to certain foods |
| <input type="checkbox"/> unaware of noxious odors | <input type="checkbox"/> dislikes carbonated beverages |

PROPRIOCEPTIVE

- | | |
|--|---|
| <input type="checkbox"/> loves to be held tightly | <input type="checkbox"/> seeks pressure on his body |
| <input type="checkbox"/> breaks toys, squeezes objects | <input type="checkbox"/> crashes into things (on purpose) |
| <input type="checkbox"/> pushes too hard on objects | |

AUDITORY (sound)

- | | |
|---|--|
| <input type="checkbox"/> over-sensitive to loud sounds | <input type="checkbox"/> diagnosed speech problem |
| <input type="checkbox"/> likes to make loud sounds | <input type="checkbox"/> diagnosed hearing problem |
| <input type="checkbox"/> misses sounds, difficulty following directions | |

VESTIBULAR (movement)

- | | |
|--|---|
| <input type="checkbox"/> experiences car sickness | <input type="checkbox"/> avoids balance activities |
| <input type="checkbox"/> reacts fearfully when moved | <input type="checkbox"/> clumsy/falls down/runs into things |
| <input type="checkbox"/> dislikes merry-go-rounds, tire swings | <input type="checkbox"/> has difficulty sitting still |
| <input type="checkbox"/> seeks excessive movement | |

REGULATORY

- | | |
|---|--|
| <input type="checkbox"/> easily distracted | <input type="checkbox"/> short attention in group activity |
| <input type="checkbox"/> difficulty with bowel/bladder training | <input type="checkbox"/> dislikes changes in routine |
| <input type="checkbox"/> difficulty with sleep patterns | <input type="checkbox"/> unusually high energy level |
| <input type="checkbox"/> problems with appetite control | <input type="checkbox"/> unusually low energy level |

MUSCLE TONE

- | | |
|--|--|
| <input type="checkbox"/> poor posture | <input type="checkbox"/> tires easily |
| <input type="checkbox"/> poor strength and endurance | <input type="checkbox"/> often props head in hand at table |



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AUDITORY SENSITIVITY CHECKLIST

Observation of several of the following items in a person may indicate auditory (hyperacute hearing) problems.

MEDICALLY

_____ has a history of hearing loss _____ has a history of ear infections

ATTENTIVENESS

- _____ Does not pay attention (listen) to instruction 50% or more of the time
- _____ Does not listen carefully to directions, often necessary to repeat instructions
- _____ Says "Huh?" and "What?" at least five or more times per day
- _____ Cannot attend to auditory stimuli for more than a few seconds
- _____ Has a short attention span of : _____ 0 - 2 _____ 2 - 5 _____ 5 - 15 _____ 15 - 30 minutes
- _____ Daydreams, attention drifts, not with it at times
- _____ Is easily distracted by background sound(s)

PHYSICALLY

- _____ Startles easily in response to sound stimulus
- _____ Covers ears when sounds are objectionable
- _____ Responds to various sounds with wide open eyes and flared nostrils

ACADEMICALLY

- _____ Has difficulty with phonics
- _____ Experiences problems with sound discrimination
- _____ Forgets what is said in a few minutes
- _____ Does not remember simple routine things from day-to-day
- _____ Displays problems recalling what was heard last week, month, year
- _____ Has difficulty recalling a sequence that has been heard
- _____ Experiences difficulty following auditory directions
- _____ Frequently misunderstands what is said
- _____ Does not comprehend many words, poor verbal concepts for age/grade
- _____ Learns poorly through verbal instruction
- _____ Has a language problem (morphology, syntax, vocabulary, phonology)
- _____ Has an articulation (phonology) problem
- _____ Cannot always relate what is heard to what is seen
- _____ Lacks motivation to learn
- _____ Displays slow or delayed response to verbal stimuli
- _____ Demonstrates below average performance in one or more academic areas



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NOTICE OF PRIVACY PRACTICES

Our commitment at Children's Therapy Works, Inc. is to serve our clients with professionalism and caring. We want to protect the privacy and security of all Protected health Information.

During the course of serving your interests, it may be necessary to share information with other health care providers or business associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a specialized study (such as a swallow study).
- For payment purposes, we may use the services of a billing service and/or billing clearing house software.
- During health care operations, we may need a specialized evaluation and/or consult services.

At Children's Therapy Works, Inc. we are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with your written authorization (parent, or legal guardian of a minor). This written authorization may be revoked at any time by the individual (parent, or legal guardian of a minor) as provided by law.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer **Mary Nastan** at **941-379-3725**.

I have read and understand the above Notice of Privacy Practices.

Signed _____ Date: _____
(Client, Parent, or legal Guardian)



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CONSENT OF DISCLOSURE

I hereby give consent to Children's Therapy Works, Inc., and all health care providers furnishing care within Children's Therapy Works' facilities, to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

You can cancel this consent at any time. Your cancellation must be in writing, signed by you or on the behalf of a minor by parent or legal guardian, and delivered to the address at the top of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by calling our Privacy Officer, Mary Nastan at 941-379-3725.

PRINT Name of Client: _____

SIGN: _____ Date: _____

If you are signing as the client's representative:

PRINT your Name: _____

RELATIONSHIP: _____

CANCELLATION

I hereby void the consent given above.

PRINT Name of Client: _____

SIGN: _____ Date: _____

If you are signing as the client's representative:

PRINT your Name: _____

RELATIONSHIP: _____