P.A.T. Kids
Pediatric Advanced Therapy

Checklist for Physical Therapy

___ Completed Intake Paperwork

___ Previous OT/PT Information

___ Allergy Notification

___ Current school patient attends _____

___ Current copy of IEP for patients 3 years and older

___ Check here if patient does not have an IEP

___ Copy of Insurance/Medicaid Card

P.A.T. Kids
Pediatric Advanced Therapy

_____ is scheduled for

a(n) ____OT / PT / Speech__ Evaluation____on_____

at _____ with _____.

DIRECTIONS TO OUR CLINICS

Please print, complete fully, and bring this new patient packet with you to the evaluation.
Please bring your child's insurance and/or Medicaid card with you.
Please bring a copy of your child's IEP, if applicable.
*****Please bring any past evaluations your child may have.****

PLEASE FOLLOW THE DIRECTIONS BELOW! (MapQuest and GPS are not always accurate in locating our offices!)

MOORESVILLE, NC LOCATION

From Charlotte: Take I-77 North to exit 36. At top of ramp, turn right onto Hwy. 150 East.
From Statesville: Take I-77 South to exit 36. At top of ramp, turn left onto Hwy. 150 East.

You will go past the Walmart on the right, and Belk and Kohl's on the left.
At next traffic light, turn left onto Corporate Center Dr. (by Zaxby's).
At stop sign, go straight onto Upper Crest into Talbert Pointe Business Park.
At stop sign turn left onto Overhill Drive (by AcroFitness).
Turn right onto Infield Court. We are located at the bottom of the cul de sac
134 Infield Court Mooresville, NC 28117

CHARLOTTE, NC LOCATION

2520 Whitehall Park Drive Suite 350 Charlotte, NC 28273

SALISBURY, NC LOCATION

Our office is adjoined to/in the same building as Salisbury Pediatrics.
129 Woodson Street Salisbury, NC 28144
**Please see the next page for more details about this location.

IMPORTANT: ALL PAPERWORK MUST BE COMPLETED BEFORE YOUR CHILD'S EVALUATION!

704-799-6824 Fax: 704-799-6825 www.pediatricadvancedtherapy.com

SALISBURY LOCATION DETAILS

Please enter through the
main lobby door
at Salisbury Pediatrics and wait
in the far left lobby (near the pharmacy) for your therapist to come out and greet you.
You do not need to check in with the Salisbury Pediatrics staff.

****Please do not enter through the side door as treatment may be in session.**

INSURANCE PAYMENT ESTIMATES:

The benefits quoted to us by your insurance are as follows*:

You are financially responsible for:

☐ $_____ Individual Deductible

☐ $_____Family Deductible

****The evaluation will cost approximately $_____. If you have NOT yet met your deductible (either individual or family), treatment sessions will approximately be $_____ until the deductible is met. Once met, each visit should be about $_____ per session.****

Self-pay rates (if not filing to insurance): $95.00 for evaluation and $80.00 per treatment session.

☐ $ _____ Co-pay

☐ _____ % Co-insurance

☐ $0 due because your child has Medicaid

☐ Your plan is limited to _____visits per _____.

☐ No visit limit.

Other:

_____

_____

_____

Payment is expected at the time of service.

We accept cash, check, discover, visa or mastercard.

Notice of Privacy Practices is on the back side of this sheet for your records.

** This information was given to us by your insurance company. You should also call your insurance company to verify your benefits. Discrepancies should be taken up with your insurance company, not PAT. These are just estimates and until we receive the Explanation of Benefits from your insurance company, we are unable to predict exact payments.*

IMPORTANT: ALL PAPERWORK MUST BE COMPLETED BEFORE YOUR CHILD'S EVALUATION!

Dear Parent(s) or Guardian(s),

Pediatric Advanced Therapy is committed to providing you and your family with the best possible care. Please understand that our office policies are in place to ensure that we are able to continue to provide excellent care to all of our patients. Your understanding of these policies is a vital piece to your child's progress in treatment, and we invite you to ask if you have any questions at any time.

As a courtesy for our patients' families, we will call your insurance carrier before treatment begins to verify coverage and benefits. The information we obtain is not a guarantee of payment; your insurance will process the claims based on your specific policy, medical necessity, and any exclusions or limitations attached to your plan. It is important that you understand that you will be responsible for any charges not covered by your insurance plan including—but not limited to—deductible, co-insurance, and co-payments. In addition, many insurance plans have a maximum number of therapy visits covered per year, with anything in addition being the responsibility of the patient. We do have a reduced, self-pay rate that we will apply if/when this occurs.

I have read and understand the financial policy for Pediatric Advanced Therapy, and agree to be responsible for any charges accrued on my account. I agree to keep my account current by either paying at the time of service or within 30 days of invoice. I understand that a member of the office staff will always be available to answer any questions I may have regarding my account.
Attached you will find the information we received from your insurance company, with a quote of expected benefits and patient out-of-pocket portions.

Printed Name Signature Date

Automatic Debit and Credit Authorization Form

This form is to allow Pediatric Advanced Therapy to withdraw funds from your designated Credit Card or Debit Card to make your monthly account payments.

I hereby authorize Pediatric Advanced therapy to charge my credit/debit card indicated below on the day of each month (as indicated on my installment contract). I understand that if my card is declined Pediatric Advanced Therapy will continue to run the authorized payment request daily until funds are available and the payment has been posted to my account.

This authority is to remain in full force and effect until Pediatric Advanced Therapy has received notification from me (or either of us) of its termination or until my account balance has reached zero.

My first payment of $_____ will be debited on _____ and every payment thereafter will be debited on the _____ day of the month.

Credit Card: _____ Visa ____ MasterCard

Other

Name on Card: _____

Card Number: _____ - _____ - _____ - _____

Expiration Date: ___/___ Security Code: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient Name: _____

Parent/Guardian Name: _____

Signature _____

Date: _____

Has your child received services anywhere else? Y or N

If yes…

When:_____

Where:_____

Which therapy:_____

Discharged: (Y or N)

Date of discharge:_____

Is the child receiving services right now (including school)? (Y or N)

If yes…

Where:_____

Name of therapist:_____

Which therapy:_____

How many times a week:_____

If school, what day of the week:_____

Do you authorize Pediatric Advanced Therapy to contact other providers? (Y or N)

If yes, please sign the consent form attached.

CONSENT FOR THE RELEASE & EXCHANGE OF INFORMATION

I give permission for the exchange of information (verbal and/or written) regarding my child,

_____,

(Child's Name)

to be shared between Pediatric Advanced Therapy and

_____

(Name/Position)

_____

(Agency/School)

_____

(Address/Phone)

I understand that unless otherwise indicated, this information will be used only for treatment or educational purposes such as assessments, curriculum programming and coordination of services.

I also understand that the agency receiving this information will be responsible

for the confidentiality of this information

_____

(Parent)

_____

(Date)

IMPORTANT!

Please arrive 15 minutes **before** your scheduled appointment.

ALL paperwork must be completed prior to your appointment and turned in at the window upon arrival.

What to Expect During the Evaluation

- Please arrive 15 minutes before your scheduled appointment with all of your paperwork completed.
- Our front office staff will discuss your insurance with you upon arrival if it has not already been discussed over the phone.
- Your evaluating therapist will review your paperwork and come greet you in the lobby.

During the evaluation:

- Parents are welcomed to come back into the treatment rooms during the evaluation to speak with the evaluating therapist.
- Please share your concerns for your child, medical and developmental history as well as challenges that occur within your daily routine. It is helpful to know how they do in a variety of settings as well, not just at home with you, i.e. school, play dates etc.
- Please share any precautions or limitations your child may have with regard to physical movement, environmental or food allergies.
- The evaluating therapist will complete structured and unstructured clinical observations of your child's movement patterns, sensory processing and age appropriate skills.
- The evaluating therapist will most often provide questionnaires for you to complete during your time and at this point may ask you to fill these out in the lobby while they complete additional standardized testing in a small room at a table (where appropriate). Parents are always welcome to stay for the duration if they prefer and with younger children and infants, that is typical.
- At the end of the evaluation, your therapist will share with you deficits that have been noted and decide whether or not your child requires skilled therapy intervention.
- If therapy is required, it is best to discuss days and times with the office staff before you leave so that they can begin working to find you an appointment time.
- Before you leave, you will receive educational handouts about what to expect from treatment as well as basic information regarding your child's specific difficulties.
- Your therapist will compile test scores and a written report with treatment goals.
- You can expect a report to be mailed to you within 2 weeks or sometimes it will be given to you at your next appointment.

If you have any questions, please feel free to call and ask prior to your appointment, or you can ask the evaluating therapist or office staff upon arrival. We look forward to working with you and your child to help them reach their full potential!

Sincerely,
The PAT Staff

Date: _____

NEW CLIENT INFORMATION

Referred by: _____

Welcome to Pediatric Advanced Therapy (formerly Integrative Therapy Concepts)

We look forward to working with your child. Please provide us with the following information:

Client's Name: _____ _____ _____
First M Last

Client prefers to be called: _____ Date of birth: _____/_____/_____

Parents' names(s): _____

Home phone: _____ Cell phone: _____ Work phone: _____

Email address: _____

Home address: (if using a PO Box, you must also list a physical address) _____

City: _____ State: _____ Zip Code: _____

Patient's School Name & Current Grade: _____

Emergency contact: _____ Phone#: _____

Relationship to client: _____

Pediatric Physician & Practice: _____Phone#: _____

ACKNOWLEDGEMENT and ASSUMPTION of RISK

I acknowledge and agree to have my child (or the child under my care), receive physical therapy services from Pediatric Advanced Therapy. I acknowledge that there is some risk inherent in the use of the therapy equipment and I agree to assume such risk and indemnify and hold Pediatric Advanced Therapy and its staff, harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child or our belonging.

MEDICAL TREATMENT RELEASE:

In the event of an emergency situation at Pediatric Advanced Therapy, I give the staff of PAT my permission to initiate emergency medical services for the child listed above if I am not present during the emergency. My hospital preference is _____, however I acknowledge that Pediatric Advanced Therapy will not be held responsible for hospital or EMS providers designated.

Please note: If your child has any of the following conditions it is <u>mandatory</u> that you remain on the premises during his or her therapy session. These conditions include: Seizures, severe allergies, significant behavioral issues, and any condition that requires medicine to be controlled. This is for the safety of your child and the protection of our staff.

(1) PRIMARY INSURANCE COMPANY: _____ Phone #: _____

ID# _____ Group # : _____

Policy Holder: _____ Date of birth: _____/_____/_____ Employer: _____

(2) SECONDARY INSURANCE COMPANY: _____ Phone #: _____

ID# _____ Group # : _____

Policy Holder: _____ Date of birth: _____/_____/_____ Employer: _____

ASSIGNMENT OF INSURANCE TO PEDIATRIC ADVANCED THERAPY:

I authorize direct payment of medical benefits to Pediatric Advanced Therapy. The benefits referred to herein would be payable to me (policy holder) if I did not make assignment and include Major Medical Insurance. **I understand that I am personally responsible to Pediatric Advanced Therapy for any and all payments not covered by the insurance companies, such as co-payments, co-insurance, deductibles and denied services. All payments are due at the time of service.**

The attending therapist is authorized to release any medical information required in the administering of applications for financial coverage for service required. He/she may also send the results of the evaluation and recommendations to my referring physician for coordination and continuity of care. I have carefully completed this form and to the best of my knowledge it does not contain any false, incomplete or misleading information.

Signature: _____ Date: _____

PLEASE COMPLETE THE BACK SIDE/NEXT PAGE!

POLICIES & PROCEDURES *Revised 2/4/2015*

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the services you receive at Pediatric Advanced Therapy. We are required by law to inform you of the "class of persons" who will have access to your medical information in order to carry out their job duties. This would include our therapy staff, administrative & billing staff and management. We may use and disclose your medical information for the purpose of treatment, payment and health care operation activities.

All evaluations usually last for one hour. It is the responsibility of the parent/guardian to bring all pertinent information to the evaluation. This includes your completed paperwork, insurance card, Medicaid card, and any medical history and/or past evaluations your child has received. You will need to be present for the first 20 minutes of the evaluation so that the therapist can ask you some questions. The remainder of the evaluation time will include clinical observation and in most cases, standardized testing. For liability reasons, we can only allow the children who are being treated into the gym and therapy rooms. **Siblings MUST stay in the lobby, NO EXCEPTIONS.**

Occupational and Physical Therapy sessions last for 50 minutes. Following the session is a 10 minute window to discuss your child's therapy with the therapist. It is mandatory that you are in the lobby during this 10 minute time frame. Please have your child use the restroom prior to the treatment session. Speech Therapy evaluations last for one hour and treatment sessions are 30 minutes.

If you leave the clinic while your child is in session, you **MUST** leave a phone number where you can be reached. You must return to the clinic before your child's session ends. This allows time for the therapist to speak with you regarding your child's treatment and progress, and also keeps the next client's session on schedule. **Please note: If your child has any of the following conditions it is <u>mandatory</u> that you remain on the premises during his or her therapy session. These conditions include: Seizures, severe allergies, significant behavioral issues, and any condition that requires medicine to be controlled. This is for the safety of your child and the protection of our staff.** If you arrive late for your session, your appointment will still end at the original end time.

Please try to give 24 hour notice when cancelling an appointment. (Occasional last minute emergencies are understood.) If you call after hours, please leave a message on our answering machine. Frequently cancelled appointments (3 within a 6 week period) will be basis for removal from our permanent schedule. When we establish a treatment plan for your child, we base our goals on the child having consistency. If your child misses appointments, they will not meet their goals as quickly, and your child will have to be enrolled in therapy for a longer period of time. The success of our treatment sessions depends on consistency. Medicaid and insurance companies require us to report attendance and show progress towards goals. In the event that you do have to cancel, we strongly encourage you to schedule a make-up appointment, even if it is with another therapist. It is often beneficial for your child when another therapist treats him or her because it gives the regular attending therapist another opinion or ideas for your child. Our staff is always in close communication with each other.

In the event that the therapist needs to cancel, we will reschedule your child with another therapist for continuity of treatment.

Failure to cancel or to appear for an appointment is considered a "NO SHOW." We will charge a $25.00 fee for "NO SHOW" appointments. After 3 "NO SHOW" appointments or late cancellations your appointment spot will be terminated. Please see our attached cancellation policy for further details.

At Pediatric Advanced Therapy, we will file with your insurance company as a courtesy. It is important for you to understand that when we contact your insurance company to verify benefits, they are only providing us with a quote. You should also call your insurance company to verify your benefits and check your benefits in your plan booklet. Many insurance plans have a limited number of visits for outpatient therapies. It is your responsibility to keep track of the number of visits your child has used. **Verification of coverage is NOT a guarantee of payment. Benefits and payment will be determined by your insurance company once the claims are received.** Any payments not covered by insurance or Medicaid will be the sole responsibility of the parent/guardian.
<u>All payments are due at the time of service.</u> We are required under contractual agreements with insurance companies to collect co-payments at the time of service. If you have a deductible that has not been met you should be prepared to pay the full allowable amount at each visit until your deductible is met. (*For example, if you have a $500 deductible, this means that your insurance company will not pay any money towards your medical expenses until YOU, the member, have spent $500 of your own money towards medical expenses.)*

- ⇨ ***I understand that I MUST return 10 minutes before my child's session ends.*** _____ (please initial here)
- ⇨ ***I understand that I will be billed for "NO SHOW" and late cancellation appointments.*** _____ (please initial here)
- ⇨ ***I agree to the payment terms listed above.*** _____ (please initial here)

I have read the Policies & Procedures listed above and have received a Notice of Privacy Practices from Pediatric Advanced Therapy.

Signature of parent/guardian: _____ Date: _____

Pediatric Advanced Therapy will be collecting video and photograph records of your child's performance during therapy sessions for their electronic medical record. I understand and consent, as this will benefit their therapy program.

Signature of Parent/Guardian: _____

Date: _____

Additional Options

I consent for photographs/videos to be used in office for staff wide trainings: Y/N

Signature: _____

I consent for photographs/videos to be used for research: Y/N

Signature: _____

PHYSICAL THERAPY INTAKE FORM (SCHOOL AGED 3+)

Thank you for taking the time to thoroughly complete this questionnaire! Our therapists need an accurate picture of your child's history to establish a treatment plan individualized to his/her needs. We are looking forward to working with you!

CURRENT FAMILY SITUATION:

Caregiver #1
Name: _____ Age: _____
Relationship to child: Mother □ Father □ Step-Parent □ Adoptive Parent □ Foster Parent □ Other
Home Address:_____
Home Phone:_____ Work Phone:_____ Cell phone: _____
Occupation:_____

Caregiver #2
Name: _____ Age: _____
Relationship to child: Mother □ Father □ Step-Parent □ Adoptive Parent □ Foster Parent □ Other
Is address different from primary caregiver? Yes □ No □
With which caregiver(s) does the child live? Both □ Mother □ Father □ Other(s)_____
Are parents are separated or divorced? Yes □ No □
Primary language spoken in the home? _____Other languages child is exposed to?_____
Do any other adults live in the home? Yes □ No □
Name/relationship (please indicate):_____
How many children are living in the home? _____ Ages? _____

CHILD'S EVALUATION AND TREATMENT HISTORY:

Please tell us all **doctors or specialists** involved in your child's care:

Specialty of Physician	Name of Physician	Date Last Seen	Reason Seen
Pediatrician			
ENT			
Cardiologist			
Pulmonologist			
Gastroenterologist			
Nephrologist			
Neurologist			
Geneticist			
Psychologist/Psychiatrist			
Other			

Has your child been given a specific diagnosis (present or past)? Yes □ No □
(If yes, please specify. Include physician who diagnosed and age at time of onset)

□ Learning disability □ ADHD □ Autism/Asperger/PDD □ Speech/Language disorder
□ Epilepsy □ Motor delay □ Sensory integration □ Bronchopulmonary Dysplagia
□ Fragile X □ Tourette / tics □ Developmental Delay □ Behavior/emotional disorder
□ Feeding Disorder □ Genetic syndrome □ Retinopathy of Prematurity □ Periventricular Leukomalacia
□ Cerebral Palsy □ Reflux □ Seizure □ Intraventricular Hemorrhage
□ Mental Retardation/Intellectual Disability
□ Other:_____
Physician who Diagnosed:_____

Please list all medication your child takes:

Medication	Frequency	Physician who prescribed	Start date

Please **list any special tests, procedures, and/or hospitalizations** since birth (MRI, EEG):
(If yes to any of the below, please include date of test and age of child at time)
Diagnostic tests: (dates and results, if known)

☐ EEG (brain wave test) ☐ Audiology Evaluation ☐ Ophthalmology Evaluation
☐ MR ☐ CT Scan ☐ Chromosomal/DNA testing
☐ Head Ultrasound ☐ Sleep study ☐ Blood test (other than routine blood count)
☐ Ear Infections ☐Other (specify): _____

Please list all agencies and intervention services currently involved with your family. Include names of contact persons if known: _____

PREGNANCY:
Did mother receive prenatal care during the pregnancy? Yes ☐ No ☐ Starting in which month _____
Previous pregnancies? Yes ☐ No ☐ (if yes, number of pregnancies, including miscarriages):_____
Were there any complications during pregnancy? Yes☐ No ☐
If yes, please explain: _____
Were any medications or other methods used to assist with becoming pregnant? Yes ☐ No ☐
If yes, please explain: _____
Medications prescribed during the pregnancy. Please list:_____

BIRTH HISTORY:
Was infant born full term (38 weeks or greater)?: ☐ Yes ☐No
If premature, how early_____ If overdue, how late _____
Birth weight: ____lbs.____ Oz.
Type of delivery: ☐ Spontaneous ☐ Cesarean ☐ Induced (e.g. Pitocin) ☐ Twins/Multiple
☐ Head first ☐ Breech (feet first) ☐ With instruments (e.g. forceps/vacuum)
Describe any complications during delivery: _____
Did infant require supplemental oxygen? Yes ☐ No ☐ (If yes, how long:_____)
Did infant have seizures? Yes ☐ No ☐ (If yes, how long:_____)
Was infant placed in the NICU? Yes ☐ No ☐ (If yes, how long:_____)
Length of stay in hospital: Mother: ____ days Infant: _____days

CHILD'S MEDICAL HISTORY:
Date of Last Vision screening? _____ Passed? Yes ☐ No ☐
Date of Last Hearing screening?_____ Passed? Yes ☐ No ☐
Does child have any **allergies** to medication/food? Yes ☐ No ☐
If yes, please list: _____
Is child up to date on immunizations? Yes ☐ No ☐
If no, which are missing? _____

Accidents/Injuries: Age: _____ Type (head, abdomen, fracture, etc.):_____
Has child ever been unconscious? Yes □ No □ (if yes, please explain: _____)
Surgery: □ Yes □ No Reason:_____ Age: _____
Hospitalization Admissions:_____ Age:____ Reason:_____

DAILY ROUTINES:
What are your child's favorite activities/motivation? _____
What are your favorite things about your child? _____
How does child play with children his/her own age? □ Poor □ Fair □ Well □ N/A
What is the length of time your child can attend to an activity? _____
Does your child have any behavior/attention issues? _____
How many hours per night does your child sleep? _____ What time does he/she go to bed? _____
Wake up in the morning?_____ Does your child nap? □ Yes □No How long?_____

SCHOOL: (Please bring a copy of your IEP/IFSP)
Name: _____ Grade: _____
Support Services: _____
□ Individual Family Service Plan (IFSP) □ Individual Education Plan □ One-on- One Aide
□ Adapted PE □ Therapies (Occupational, Speech, Physical)
□ Involved in organized activities or sports? _____
□ Any concerns or difficulties? _____

Does your child use any of the following at home or at school?
□ Walker □ Wheelchair □ Pacifier /Bottle □ Assistive Technology
□ Orthotics □ Helmet □ Other: _____

DEVELOPMENTAL MILESTONES:

Task	**Approximate Age**
Sat without support	
Crawled on hands and knees	
Stood alone	
Walked alone	
Toilet Trained	
First Word	
Climbed onto surface (couch, chair)	
Walked up stairs without assist (with handrail)	
Walked down stairs without assist (with handrail)	
Run	
Skipped	
Rode tricycles	
Rode bike with training wheels	
Bike without training wheels	

GOALS:
Please list goals that relate to anything your child CANNOT do that interferes with his/her daily function.
1. _____
2. _____

Physical Therapy Screening Tool ("Red Flags"). Check all that apply.

Children → All Ages

— Seems clumsy or uncoordinated (taking longer than expected to learn motor skills, bumps into other people or objects in the environment, falls often, etc)

— Difficulty following verbal directions or completing steps of daily routines

— Avoid movement activities such as swings, slides, hesitates on curbs or uneven surfaces, etc

— Uses more movements and time than necessary to accomplish a task consistently

— Appears to be in constant motion, fidgety, difficult time sitting still

— Overly rough when playing

— Difficulty imitating actions

— Unsafe in community or at home

— Fall more than peers or constantly have bruises or scrapes or injuries

— Disruptive behaviors-impulsive, limited attention, resistive to new activities/changes in routine, difficulty moving fro0

— m one activity to another, gives up easily, difficulty calming self

— Look or tilt their head always to one side and/or have flattening of back or side of the head

— Walk in a way that is different from other kids their age

Physical Therapy Screening Tool ("Red Flags") – Age Specific

Birth- 6 months ⎦ Not turning head or lifting head when held or placed on tummy for play ⎦ Does not roll side to back ⎦ Does not hold body up with arms on stomach ⎦ Does not roll over back to side ⎦ Brings toys and hands to mouth and middle of body together ⎦ Does not roll back to and from tummy or push chest off floor when on tummy to initiate roll (should be developed 4-6 months) ⎦ Does not sit when placed for even a few seconds (6 months with hands down in front)	**7 month- 1 year** ⎦ Does not get on hands and knees ⎦ Does not attempt to army crawl on floor pulling body with arms and using legs to assist ⎦ Does not crawl on hands and knees (around 9 months) ⎦ Does not catch self with balance loss forward, or side to side (developed fully by 9 months) ⎦ Is not able to sit without support or get into sitting for more than 1 minute ⎦ Is not interested in standing or does not stand without hands on waist ⎦ Is not attempting to step with or without support ⎦ Does not stand without support for even a couple seconds ⎦ Does not engage with rolling or flinging small ball
1-2 years old ⎦ Does not catch balance loss in sitting backwards (by 1 year) ⎦ Does not stand well without support ⎦ Does not attempt to get up steps (may crawl or walk with hand hold near 2 years) ⎦ Is not able to stand up from floor with squat pattern ⎦ Is not walking with more steadiness or change direction with walking without balance loss. ⎦ Is not able to climb onto couch, chairs or into seat in car and turn to sit ⎦ Is not able to kick or step on ball without fall ⎦ Is not able to walk backwards or carrying toy ⎦ Is not able to throw ball overhand	**2-3 year olds** ⎦ Does not run or jump without balance loss (by 2 years old) ⎦ Does not walk up and down steps without handrail (can put both feet on same step) ⎦ Does not throw small ball with close to target aim underhand pattern. ⎦ Does not stand on one foot for 1-2 seconds (about 2.5 years old) ⎦ Does not walk on tip toes ⎦ Does not throw overhand pattern (2.5 years old) ⎦ Does not jump down large step with feet together without balance loss (around 2/5 years old)
3- 4 years old ⎦ Is not able to jump down/forward feet together ⎦ Does not walks up stairs without handrail or 2 feet on same step ⎦ Does not attempt to pedal tricycle ⎦ Is unable to avoid obstacles with path change ⎦ Is unable to kick ball 5-6 feet or catch a ball thrown to them ⎦ Is unable to stand on one foot for 5 seconds or on tip toes in place ⎦ Unable to walk narrow line without fall or step off ⎦ Unable to throw ball over and underhand with target contact	**5-6 years old** ⎦ Is unable to do summersault/tumble over ground ⎦ Is unable to skip or gallop with model of pattern ⎦ Is unable to hit a target with ball thrown 12 feet ⎦ Does not catch small or bounced ball with hands only ⎦ Is unable to stand on one foot >10 seconds ⎦ Is unable to complete pushups or sit ups (form not important but clearing part of upper body) ⎦ Is not able to walk on tip toe 15 feet or more. ** **by 7-12 years old the child should move and walk very similarly in pattern to an adult and demonstrate smooth movements with tasks like bike, jumping jacks and ball skills.**

Cancellation Policy

Effective March 2,2018

Pediatric Advanced Therapy aims to provide the highest quality of care to all patients. In the interest of all of our patients, we are implementing a 24 hour cancellation policy effective January 1, 2017. All cancellations require 24 hours notice to avoid a cancellation fee. By implementing this policy, we will have the ability to replace cancelled appointments with patients in need and provide the best care for our collective patients.

Our policy is as follows:

1. Patients that cancel with more than 24 hours notice will not be subject to a cancellation fee. If a patient cancels more than 3 times in a 10 week period, they are subject to being removed from the permanent schedule.
2. Any patient that no shows for an appointment without a prior call will immediately be subject to a $25 no show fee.
3. Any patient cancelling with less than 24 hours' notice will be subject to a $25 cancellation fee.
   *If a patient schedules and attends a make-up session within the week of (or the week following) the cancellation, the cancellation fee may be waived.
4. If you cancel 2 weeks in a row due to sickness, we require a doctor note in order to attend next session.

If you have questions or would like to discuss your scheduling needs, please call

704-799-6824.