



Checklist for Speech Therapy

___ Case History

___ Previous Speech Therapy Information

___ Allergy Notification

___ Discussion Authorization

___ Current school patient attends _____

___ Current copy of IEP for patients 3 years & older

___ Check here if patient does not have an IEP



_____ 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

We are located at 129 Woodson Street in Salisbury.

Our office is adjoined to/in the same building as Salisbury Pediatrics.

Please enter through the lobby door closest to the pharmacy.

Your therapist will come out to greet you.

Please do not check in with the Salisbury Pediatrics staff.

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): \$117.00-\$155.00 for evaluation and \$66.00 per 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!



Speech Therapy

Self – Pay Prices

Speech Evaluation: \$117.00 - \$155.00

Speech Session: \$66.00/session



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



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,

PATStaff

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: _____

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 occupational 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 mandatory 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 mandatory 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.

All payments are due at the time of service. 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: _____

I consent for photographs/videos to be used for media purposes (i.e. marketing/website): Y/N

Signature: _____

Speech Therapy: Caregiver Questionnaire

Child's Name: _____ Age: _____

DOB: _____ Gender: Male Female

Completed by: _____ Relationship to Child: _____

Child's Primary Language: _____ Language Spoken at Home: _____

Child's Address: _____ City: _____ Zip: _____

Evaluation:

Please describe why you are having your child seen for a speech therapy evaluation (e.g. voice, stuttering, expressive language delay (spoken language), receptive language delay (understanding), articulation, reading difficulty, feeding, oral motor etc.):

How does the child usually communicate (gestures, single words, short phrases, sentences)?

When was the problem first noticed? By whom?

What languages does the child speak? What is the child's dominant language? What languages are spoken at home? What is the dominant language spoken at home?

Does the child have any favorite toys or play activities?

Does your child have difficulty separating from you?

Prenatal Birth/Delivery:

Mother's health during pregnancy: _____

Length of Labor: _____ Birth Weight: _____

Was the pregnancy full-term? Yes No

If premature, please specify number of weeks: _____

Delivery (check all that apply): Vaginal Breech C-section Twins

Were there any pregnancy or delivery complications? _____

Any medical assistance required for the mother or the baby? _____

Did the baby have any of the following? Jaundiced Cyanosis (blue baby) Breathing difficulty Feeding difficulties-breast or bottle Colic Seizures Other

Feeding: Breast-fed Bottle-fed Nutritional Disturbances

NICU stay?

Describe feeding difficulty: _____

Medical History:

Child's current health status (please circle one):

- Excellent Good Fair Poor

Does child have any current medical diagnoses? (e.g. Autism, ADD/ADHD, etc.):

Is the child taking any medications (y/n)? If yes, please explain:

Does your child have any known allergies: (y/n) If yes, identify:

Food allergies

Dietary restrictions

Vision impairment

Glasses: Yes No

Hearing impairment

History of ear infections (y/n)? If yes, please explain:

Hearing aid: Yes No

Tubes in ears: Yes No

Has the child ever been seen by an Audiologist or ENT in the past? If yes, please explain

Any hearing concerns/issues:

Tonsils/Adenoids removed: Yes No If yes, when?

Current physician's name:

Has your child had any of the following? (Please check ALL that apply and list age of occurrence if applicable):

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Pneumonia Influenza | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High Fevers | <input type="checkbox"/> Whooping Cough | |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Seizures | <input type="checkbox"/> Respiratory Illness | |

Surgeries/Infections

Other medical concerns:

Have any other specialists (physicians, allergists, audiologists, psychologists, psychiatrists, chiropractors, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

Do any of the following appear to be difficult for your child?

- Eating a variety of food Yes No
- Drizzling Yes No
- Swallowing while eating or drinking Yes No
- Dysfluent or stuttering Yes No
- Expressing thoughts and ideas clearly Yes No
- Following directions or routines Yes No
- Combining words or verbalizing communication Yes No
- Understanding what he/she hears Yes No
- Pronouncing words correctly Yes No
- Answering questions correctly Yes No

Developmental History: (*These can vary within normal range)

Milestone	Typical Age Mastered	Age completed
Rolled over	6 months	_____
Babbled	6-7 months	_____
Began to eat solid pureed food	6 months	_____
Sitting	6-7 months	_____
Crawled	6-9 months	_____
Began to eat hard dissolvable foods	9-10 months	_____
Drank from a sippy cup	10-12 months	_____
Walked	11-13 months	_____
Spoke Single words	12 months	_____
Combined words	2 years	_____
Walks on stairs	24-30 months	_____
Spoke in sentences	2 ½ years	_____
Toilet trained	3 years	_____
Self fed with utensils	3 ½ years	_____

Social and Play Skills

- Responsive to social stimuli; facial expressions of emotion
- Socially interactive; playing games (i.e. patty cake) with caretaker
- Solitary play (playing alone)
- Imitation of actions, songs, words
- Parallel play
- Symbolic play (Using objects to represent other objects in play)
- Cooperative, imaginative play- may involve fantasy and imaginary friends
- Turn taking in games
- Using gestures to communicate (e.g. pointing reaching)

Does your child do the following?

- Identify pictures in books Yes No
- Engage in conversation Yes No
- Follow simple 1-step directions Yes No
- Follow multi-step directions Yes No
- Engage in creative play Yes No
- Express difficulty feeding Yes No
- Express difficulty sleeping Yes No
- Make friends easily Yes No

Do you have any concerns with your child's strength or coordination? Yes No

Does your child use any special equipment (wheelchair, braces, etc.)? Yes No

Please indicate any safety concerns your child may have:

- Self-abusive Yes No
- Abusive towards others Yes No
- Run from building premises Yes No
- Other _____

Family History:

History of Speech Disorder: Yes No

Type of Speech Disorder (who and what type of disorder):

Any additional family history relevant to speech and language disorders:

Educational History:

School: _____ Grade: _____

Teacher(s): _____

Please list any services that your child is (a) currently receiving or (b) has received in the past. Please include dates of service. (i.e. physical therapy, occupational therapy, speech therapy, early intervention, school services, etc.)

(a) _____

(b) _____

Speech Therapy Frequency: 1x/2x/3x per week _____

How is the child doing academically (or pre-academically)? _____

If enrolled for special educational services, has an Individualized Education Plan (IEP) been developed? If yes, describe some of the goals. _____

***Please note: If school services are provided, we will need to have an IEP on file at the clinic before therapy services can begin.**



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.***