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

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www.pediatricadvancedtherapy.com

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

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.

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

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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.

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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 Discounted Prices

Speech Evaluation: $117. 00 - $155.00

Speech Packages (to be purchased in advance):

- **Buy 1-3 sessions: $66.00/session**
- **Buy 4-9 sessions: $64.00/session**
- **Buy 10+ sessions: $62.00/session**

Packages will expire after 6 months from date of purchase

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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.

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Printed Name Signature Date

Case History

Child's Name:_____ Age: _____

DOB:_____ Gender: ☐ Male ☐ Female

Completed by:_____ Relationship to Child: _____

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

Child's Address:_____City :_____Zip:_____

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

_____

_____

_____

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

_____

_____

Currently receiving speech therapy? Y or N If so by whom & when: _____

Frequency: 1x / 2x / 3x per week

Why was therapy recommended: _____

_____

How long did the child receive services: _____

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Current School Name:_____

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Check any items that have been observed with your child or appear difficult for them:

Eating a variety of foods	Following directions or routines
Drooling	Combining words or verbalizing communication
Swallowing while eating or drinking	Understanding what he/she hears
Dysfluent or stuttering	Pronouncing words correctly
Expressing thoughts and ideas clearly	Answering questions correctly

Family History:

Father's Name:_____

History of Speech Disorder: ☐ Yes ☐ No

Type of Speech Disorder (if applicable)_____

Mother's Name:_____

History of Speech Disorder: ☐ Yes ☐ No

Type of Speech Disorder (if applicable):_____

Siblings and any history of speech disorder: _____

_____

_____

Any additional family history relevant to speech and language disorders:

_____

_____

_____

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Physiological Information

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: _____

_____

Date of most recent physical examination or doctor's visit: _____

Current physician's name: _____Phone: _____

Physician's address: _____

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

☐ Chicken Pox	☐ Measles	☐ Scarlet Fever	☐ Rheumatic Fever
☐ Pneumonia Influenza	☐ Asthma	☐ Hay Fever	☐ Earaches
☐ Diphtheria	☐ Encephalitis	☐ Mumps	☐ Meningitis
☐ Allergies	☐ High Fevers	☐ Whooping Cough	
☐ Ear Infections	☐ Seizures	☐ Respiratory Illness	

Surgeries/Infections_____

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Hearing

History of ear infections? ☐ Yes ☐ No Please explain_____

Has this child ever been seen by an Audiologist or had any otological care/surgery done in the past? If yes, please explain_____

Any hearing concerns/issues:_____

Delivery:

Mother's health during pregnancy:_____

Length of Labor:_____Birth Weight:_____

Was child born premature? ☐ Yes ☐ No

Delivery (check one): ☐ Vaginal ☐ Breech ☐ C-Section

Child's Condition at Birth: ☐Jaundiced ☐Blue ☐ Breathing ☐ Other

Feeding: ☐Breast-fed ☐ Bottle-fed ☐ Nutritional Disturbances

Any complications during pregnancy or delivery:_____

_____

_____

Developmental Milestones (Please list approximate ages):

First tooth_____ Sitting Alone_____ Crawling_____

Walking_____ Dressing_____ Self-feeding_____

Potty trained_____ First Word_____

Additional Pertinent Information_____

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Previous Speech Therapy Information

Has your child received Speech Therapy in the past 12 months by another provider?

☐ No

☐ Yes

If you are not sure if your child has been discharged from the other provider, please sign below to authorize that you are requesting Speech Therapy services from Pediatric Advanced Therapy.

Child's Name:_____DOB:_____

Previous Speech Therapist and Provider:_____

Date of last treatment:_____

_____ _____

Printed Name of Parent/Guardian Signature

_____

Date

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Allergy Notification

From time to time your child's therapist may utilize examination gloves and various foods in the course of therapy to assess or stimulate certain speech related behaviors. We are aware of the fact that some children are allergic to the materials in examination gloves and may be on specialized diets or have food allergies. Please read the following lists carefully and indicate any allergies you know your child has. Please list any other known allergies in the space below. This information will be noted in a prominent place on your child's chart. Please keep your child's therapist informed of any allergic reaction, which are identified in your child over the course of his/her therapy program. Your child's health and safety are of the utmost importance to us.

The following are some of the foods and substances commonly used in therapy. Please circle any that your child is allergic to OR any which are not part of your child's special diet.

Talc (powder)	latex
Chewy sweet tarts	chips (Lays, Doritos, Fritos)
Pretzels	chocolate M&M's
Starburst	gummy worms
Hot tamales	Skittles
Juice	applesauce
Powder sugar (very small amounts)	pixie sticks
Dried cereal (Cheerios, Fruit loops)	hard candy (lollipops)

Please list ANY other known allergies:

_____

_____

_____

If your child has no known allergies, please write "**NO KNOWN ALLERGIES**" in the blank below before signing this form.

_____

I have provided the information above to the best of my knowledge at the request of Pediatric Advanced Therapy and will notify my child's therapist of any change in the status of the above information.

Child's Name: _____

Responsible Party: _____

Today's Date: _____

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Discussion Authorization

Patient's Name:_____DOB:_____

I_____herby authorize and request the speech therapists at Pediatric Advanced Therapy to discuss any information to include therapy sessions, progress, treatment plan, etc. about the patient named above. I authorize these discussions to be held: (**Please initial by one**)

_____in the lobby, parking lot, etc.

_____in a therapy/conference room only

_____ _____
Parent or Guardian Signature Date

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Cancellation Policy

Please note that we have updated our cancellation policy effective 7/13/15.

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 July 13th. All cancellations require 24 hour 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 hour 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 cancellation fee.
3. Any patient cancelling with less than 24 hour notice will be allowed 2 "free passes" per 12 month period. We understand that emergencies and illnesses do happen. After 2 free passes, any cancellation with less than 24 hour 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 or free pass usage will be waived.

If you have questions or would like to discuss your scheduling needs, please call 704-799-6824.

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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 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 <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: _____