# Therapy SPOT Inc.

**S**peech **P**athology & **O**ccupational **T**herapy

*Specializing in Treating the Whole Child*

*This information helps our therapists gain a better understanding of your child, and it helps us provide the best service for you and your family. Thank you for taking the time to complete as much as you can.*

## PATIENT INFORMATION

Patient's Name_____ Date of birth_____
Mother's Name_____ Home phone_____
Email_____ Cell phone_____
Work phone_____
Father's Name_____ Home phone_____
Email_____ Cell phone_____
Work phone_____
Address_____
_____
_____

Pediatrician's name & address _____
_____
Pediatrician's phone # _____ Fax # _____

School child attends_____
Teacher's name_____ Classroom room #_____

Names of siblings in household & their ages:
_____
_____
_____

Primary language spoken at home_____
Language(s) child speaks_____

How did you find out about Therapy SPOT Inc.?_____

## STATEMENT OF CONCERNS

Describe the reasons you are seeking OT and/or Speech for your child.

_____
_____
_____
_____

## BIRTH HISTORY

Length of pregnancy _____ Birth weight_____
Mother's health condition during pregnancy_____
_____
_____
Was baby hospitalized at birth? **Yes / No**
Complications during delivery_____

## CHILD'S HEALTH HISTORY

Allergies_____
Has vision been tested? _____By whom _____When _____
Has hearing been tested? _____ By whom_____ When_____
Results of vision and hearing_____
List any medication currently being taken_____

- Laryngitis____ Seizures____ Asthma____ Frequent colds____ Frequent ear infections _____

Was child ever seriously ill? _____ At what age?_____
Describe illness_____

Was child ever seriously injured? _____ At what age?_____
Describe the injury_____

Has the child ever been hospitalized? _____ At what age?_____
How long? _____Explain _____

**DEVELOPMENTAL MILESTONES -** Age at which the following took place:
Roll over_____ Crawl_____ Sit_____ Walk_____
Drink from a cup_____ Eat with utensils_____ Toilet trained_____
How does your child communicate his/her needs? _____
Did your child babble as an infant? **Yes / No** At what age?_____
First Words _____ At what age?_____
Does your child put words together to form a sentence? _____ Age?_____
Approximately how many words does your child say? _____
Does your child use gestures to communicate? **Yes / No**
Are you able to understand your child's speech? **Yes / No**
Are others able to understand your child's speech? **Yes / No**
Is your child able to understand others? **Yes / No**
Was/is your child bottle fed? **Yes / No** Did/does your child use a pacifier? **Yes / No**
Does your child drink from a sippy cup/straws/drinking cup? _____
Does your child tolerate foods of different textures? **Yes / No**
Did/does your child experience any difficulty in sucking, chewing, biting and/or swallowing? _____

***Does your child***:
Demonstrate appropriate eye contact during interaction? **Yes / No**
Play frequently with children of the same age? **Yes / No**
Play well with other children? **Yes / No**
Play well alone? **Yes / No**
Complete an activity before beginning another? **Yes / No**
Get distracted easily? **Yes / No**
Enjoy pretend play? **Yes / No**
Cooperate with household/school rules? **Yes / No**
How active is your child? Excessive ____ Average ____ Below ____

## INTERVENTION HISTORY

Is there any family history in any of the following areas?:
Speech / Language _____
Learning _____
Neurological _____
Attention _____
Other _____

Is your child currently receiving any other services?:

- Occupational Therapy _____ Physical Therapy _____ Speech Therapy _____

Other_____

Has your child been evaluated and/or provided therapy by other professionals? Please list below the results. Neurologist, Psychologist, Psychiatrist, etc.

_____
_____
_____

## RELEASE OF INFORMATION

I, _____, hereby grant permission for therapists associated with Therapy SPOT Inc. to discuss information relating to the occupational and/or speech therapy status of my child, _____, with the following individuals:

Preschool Director_____
Classroom teacher and assistants_____
Pediatrician _____
Psychologist _____
Psychiatrist _____
Other professionals please list:_____

Only information pertinent to your child's therapy or education will be discussed.

_____

**Signature** **Print Name** **Date**

# Insurance Disclaimer

We at, Therapy SPOT Inc., **DO NOT** accept insurance. It is the client's responsibility to pay for all services rendered within 30 days of receiving the monthly statement. If you carry insurance, contact the insurance carrier to determine if the therapy recommended is covered under your plan. Therapy SPOT Inc. maintains the necessary records, as well as provides a monthly statement with the insurance required ICD-9 or ICD-10 (diagnosis) codes and CPT (procedural) codes. We will work with you in providing treatment plans and progress notes when needed, upon request. It is your responsibility to submit and collect claims from your insurance carrier for any reimbursement.

If you have an HMO, typically they require you to receive authorization for services and only from a provider under their plan. PPO and POS plans usually have in and out of network options for coverage. Some plans will even provide you with a treatment waiver when they are unable to refer you to a pediatric therapist provider that is local to you.

Please keep copies of all of your statements when submitting to the insurance company, as well as for your own private record. Be persistent. Claims are frequently denied at first, so make follow up calls and resubmit requested information. Often the information they request is already on your statement. Resubmit and review the paperwork with the insurance agent. If you misplace your statements, we will reprint them for a $.10 per page fee.

# Agreement

I understand the terms and conditions regarding insurance. I understand that a monthly billing statement, including the necessary insurance codes for reimbursement, is provided. I understand that I am responsible for all financial obligations.

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**Parent's Signature** **Date**

# Therapy Agreement

- Policy for cancellation is to notify therapist within 24 hours of service for vacation or scheduling conflict, and as soon as possible for cancellations related to illness. Please note that if you do not call to cancel, you will be considered a **no-show** and will be billed for the session. 2 consecutive **no-show** visits will result in the discontinuation of services at your standing time slot. You will need to call to resume services with no guarantee that your original time slot will still be available. This policy applies to both individual and group therapies.

- Please call therapist when anyone in the home is ill to discuss the need for canceling. Also, the therapist reserves the right to decline or cancel therapy with any child that may present as ill. Some of our clients have compromised immune systems and it is dangerous for them if we get ill or if they are exposed to sick children in our office.

- Please inform the school and complete the necessary paperwork for all school visits or consultations.

- All of our therapy sessions end 5 minutes early to allow for consultation with the parent regarding performance, progress, and homework.

- Parental follow through with homework assignments or home programming is necessary to ensure progress.

- In the event the therapist is running late for your appointment, we ask for your patience to ensure that everyone receives their scheduled amount of time. However, we will be unable to make up for missed appointment time if you, the client, are late for your scheduled appointment.

- Clients that schedule appointments during school holidays, such as winter and spring break, will be billed if missed or cancelled without advanced notice.

Please sign this form if you are in agreement and you would like to secure therapy services for your child.

_____

**Child's name**

_____

**Parent's signature** **Date**

# Payment Rates and Agreement

This is a complete list of services, including payment rates and policies. We, at **Therapy SPOT Inc.,** expect payment for **all** services rendered. We accept cash and/or check. As a courtesy to our clients, credit card payments (Visa, MC, Amex, Discover) are accepted for automatic payment plans and in-office payment. A monthly statement will be issued for services rendered upon request. Payment is expected upon receipt of the statement. Payment arrangements may be made prior to services provided by Therapy Spot Inc.

## Payment Options (*select one*)

- **Automatic payment with credit card on file (*recommended method*):**
  - Complete a Credit Card Authorization Form.
  - Credit card will be billed weekly.

- **Pay at time of service** with cash, check or credit card.

- **Payment in advance toward account:**
  - Maintain a positive balance on your account by making a deposit at the start of the month.
  - Cost of services will be deducted from the positive balance.
  - You will be notified if your positive balance is depleted.
  - A statement will be provided each month.

## Late Payment Policy

Late payments (or negative balances) exceeding 10 days of the most recent session:

- Services will be placed on hold until payment is made in full.
- Time slot will be considered open and may be filled resulting in a need to reschedule appointment times.
- Full payment must be made and credit card must be placed on file to resume services.

*To ensure that there is not a lapse in services, we recommend that each client complete a Credit Card Authorization Form and leave a credit card on file for either automatic payment, or to be used in case of emergency.*

## Payment Rates

**Occupational and Speech Therapy Screening & Treatment:**

Comprehensive Screening with consultation (up to 60 minutes) ----------$150 (50% of fee will be applied toward first therapy session)
30 minute OT/Speech session----------$75
45 minute OT/Speech session----------$112.50
60 minute OT/Speech session----------$150
Social Pragmatics Group session----------$75

**Tutoring Services**

60 minute sessions ----------$65

**Assessment Reports (upon request):**

Occupational or Speech Therapy Evaluation Report ---------- $450
Occupational or Speech Therapy Plan of Care----------$180

**Consultation Visits:**

School Observations and Meetings (up to 1 hour) ----------$180
Office Consultations/Parent Training (up to 1 hour) ----------$150
Team Meetings (up to 1 hour) ----------$180
In-Home Parent Training (up to 50 minutes) ----------$200

***Consultations over the time indicated will be billed at a rate of $75 each additional hour or portion thereof***

## Agreement

I understand the terms and conditions regarding payment for services rendered. I understand that I am fully financially responsible for all charges and/or fees.

_____

**Signature** **Date**

**Payment Rates and Agreement (Appendix 1)**

# Credit Card Authorization Form

I, *(please print name)*_____, authorize **Therapy SPOT Inc.,** to use the following credit card to process payments for services rendered according to the details outlined in the **Payment Rates and Agreement Form**.

**Credit Card Type:** **O Visa** **O MasterCard** **O Amex** **O Discover**

**Card #:** _____

**Expiration Date:** _____ **CVV#:**_____

**Cardholder Name:**_____

**Credit Card Billing Address:**_____

_____

_____

_____

**Signature** **Date**