Tender Ones Therapy Services, Inc.
2089 Teron Trace
Suite 120
Dacula, Georgia 30019

Phone: (770) 904-6009
Fax: (770) 904-2357

WELCOME

Tender Ones Therapy Services, Inc. offers Pediatric Physical Therapy, Occupational Therapy, Speech Therapy and Intensive Therapy Programs.

Enclosed please find:

1) Patient Registration Form
2) Insurance / Guarantor Information
3) Patient Consent to Treatment / Acknowledgement of Receipt of Privacy Practices
4) Notice of Privacy Practices for Protected Health Information
5) Photograph / Video Consent and Release Form

Please sign where it is indicated and return to the front office staff. If you have a prescription from your doctor please give this to the front office staff also.

If your child is evaluated and therapy services are recommended each therapist is required to maintain documentation on your child. This will include an Initial Evaluation, a Plan of Care and daily treatment progress notes. Your child's therapist will update the Plan of Care every six months and forward it to the referring physician for their signature and request a new prescription for continuation of services. Your child's therapist is interested in your goals for your child, please discuss these with them.

Attendance at scheduled therapy appointments is in your child's best interest in order to maximize their potential. We understand that emergencies and childhood illnesses arise suddenly. If you must cancel an appointment please try to do so at least 24 hours in advance if possible. This allows your child's therapist to offer make up sessions to others who have had to cancel. **You will be charged a $25 NO SHOW fee if you do not call and cancel within a reasonable time frame.** Please understand that we maintain a waiting list for therapy services. If you miss 3 appointments within 3 months without prior notifying your child's therapist we reserve the right to discharge your child from therapy for absenteeism.

We want to provide the optimum therapy session to your child. Parents are always welcome to observe their child unless it interferes with their child's level of cooperation during therapy. Some children perform optimally with their parents present and others perform better when parents wait outside. Please understand that there are times when there are other children receiving therapy in the gym area at the same time as your child. For this reason and for liability reasons siblings are welcome in the waiting area and should not enter the gym area.

If you have any questions or concerns that you would like to discuss you can contact Noreen Zulaica PT, she is the owner of TOTS and wants you to be very satisfied with all of the services your child receives here at our facility.

Parent Signature:_____ Date:_____

You can also visit us on the web at www.tenderones.com.

TENDER ONES
THERAPY SERVICES
TOTS
www.tenderones.com

Developmental/Sensory History

General Information

Child's Name: _____ _____ _____
(first) (last) (nickname)
Birth Date: _____ Home Phone: _____
Address: _____
City: _____ State: _____ Zip Code:_____
Best email address to contact you: _____
Mother's Name: _____ Occupation: _____
Employer: _____ Phone: (___) _____
Father's Name:_____ Occupation:_____
Employer: _____ Phone: (___) _____
List names and ages of siblings:

Name of emergency contact:_____
Relationship to child:_____Phone: (___) _____
Does your child attend: [ ] Nursery School/Preschool: _____
[ ] Early Intervention Program: _____
Primary Physician: _____Phone: (___) _____
Referring Physician: _____Phone: (___) _____

Diagnosis: _____

Medical Information

If your child has had any of the following, please describe and list appropriate dates.
Congenital abnormalities:_____
Surgery:_____
Serious Injury:_____
Casts or Braces: _____
Ear Infections (how frequently)/ear tubes:_____
Allergies (Including all Food Allergies):
_____
Seizures (any known triggers?): _____
Other: _____

List any medications your child is currently taking as well as frequency, dosage, and purpose:
_____
_____
Are there any medical precautions the therapist should be aware of when working with your child?
[ ] Yes [ ] No If yes, what?_____

Does your child use assistive devices (glasses, casts, wheelchair, etc.)? [ ] Yes [ ] No
If yes, please list:_____

Has your child received evaluations or treatments from the following disciplins:
(Note: please provide the office with any previous evaluations):

Type	Evaluation Date	Dates of Therapy	Professionals Name /Company name	Results
PT				
OT				
Speech				
Vision				
Hearing				

Pregnancy and Birth

1. Please list and describe if there were any complications during pregnancy, labor, or delivery:

_____

_____

_____

2. Did your pregnancy reach full term? [ ] Yes [ ] No If no, how many weeks? _____

Developmental Milestones

(Give approximate ages if remembered, or comment on anything unusual)

Roll Over		Walk		Say words	
Sit Alone		Chew solid food		Say sentences	
Crawl		Drink from a cup		Babble	

Comments: _____

Infancy and Early Childhood

Does or did your child:

1. have feeding problems? [ ] Yes [ ] No
   If yes, please describe: _____
2. have sleeping problems? [ ] Yes [ ] No
   If yes, please describe:_____
3. have colic? [ ] Yes [ ] No How long?_____
4. prefer certain positions as an infant? [ ] Yes [ ] No

If yes, please describe: _____

5. dislike lying on stomach? [ ] Yes [ ] No
6. dislike lying on back? [ ] Yes [ ] No
7. enjoy bouncing? [ ] Yes [ ] No
8. find car rides and/or infants swings calming or nauseating? _____
9. tend to always be generally compliant? [ ] Yes [ ] No
10. go through "terrible twos?" [ ] Yes [ ] No

If no, please describe your child's toddler stage:

_____

_____

Bowel and Bladder:

1. Is the child potty trained? [ ] Yes [ ] No
2. Does or did the child continue to have accidents during the day[ ], night[ ], or neither [ ]
3. Seem fearful of sitting on toilet? [ ] Yes [ ] No

Sleep Patterns:

Does your child have a regular sleep pattern? [ ] Yes [ ] No

If no, describe:

Play Skills:

1. What are your child's favorite play things?_____
2. Are there things your child tends to avoid [ ] Yes [ ] No
   If yes, please describe _____
3. Does your child tend to play alone? [ ] Yes [ ] No
4. Does your child tend to play in a certain position more than others (i.e. "W" sitting, standing up, sitting down)? [ ] Yes [ ] No If yes, what position _____
5. Does child tend to play with things by lining or piling them up (only applicable if over 2 years old)? [ ] Yes [ ] No
   If yes, describe: _____

Developmental Skills

Does your child have a hand preference? [ ] Right [ ] Left [ ] No preference

Can your child: (Ease of Performance)	Yes	No	Some difficulty	Good
1. Walk up and down stairs using rails or holding hands?				
2. Throw a ball?				
3. Catch a ball?				
4. Propel a riding toy with feet?				
5. Ride a tricycle or bike with training wheels?				
6. Pick up small objects with fingers?				

7. Turn pages of a book?				
8. Kick a ball?				
9. Stack blocks?				
10. Complete single piece puzzles?				
11. Complete interlocking puzzles?				
12. Color with crayons?				
13. Draw lines and circles?				
14. String beads?				
15. Finger feed self?				
16. Drink from a cup?				
17. Feed self with a spoon?				
18. Hold up arms and legs for dressing?				
19. Unzip a jacket?				
20. Undress self?				
21. Put on or take off shoes?				
22. Unbutton large buttons?				
23. Blow soap bubbles?				
24. Blow whistles?				
25. Drink from a straw?				
26. Kick a ball?				

Sensory History

Does your child…

Yes	No	N/A	Question	Comments
			Become easily distracted by visual stimulation?	
			Respond to having his/her name called?	
			Seem overly sensitive to sounds?	
			Seem to make sounds constantly?	
			Seem defensive or overly sensitive to some odors?	
			React aversively to the taste/texture of many foods?	
			Tend not to feel pain as much as others?	
			Tend to lack carefulness, be impulsive?	
			Frequently bump into things (chairs or doorways)?	
			Lick, suck, or chew on nonfood items (past 18 months old) If so, please list.	
			Enjoy swings?	
			Avoid climbing on equipment such as jungle gyms?	

Speech and Language:

Is there a language other than English spoken in the home? [ ] Yes [ ] No
If yes, which language? _____
Does the child speak the language? [ ] Yes [ ] No
Does the child understand the language? [ ] Yes [ ] No
Who speaks the language?
Which language does the child prefer to speak at home?
Is the child aware of, or frustrated by any speech/language difficulties?

Does your child….
Repeat sounds, words, or phrases over and over ? [ ] Yes [ ] No
Understand directions with visual cues? [ ] Yes [ ] No
Understand directions without visual cues? [ ] Yes [ ] No
Retrieve/point to common objects upon request (ball, cup, shoe)? [ ] Yes [ ] No
Respond correctly to y/n question? [ ] Yes [ ] No
Respond correctly to who/what/when/where/why questions? [ ] Yes [ ] No

Your child currently communicates using (please check)…
___Body language
___Sounds (vowels and grunting)
___Words
___2-4 word sentences
___Sentences longer than four words
___Other (communication device, ASL, etc)

What are your speech and language concerns?
_____

Do you have concerns about your child's oral motor skills (drooling, difficulty sucking, difficulty chewing)? _____
Does your child have any history of feeding or swallowing problems? [ ] Yes [ ] No
What is your child's current diet? (puree, mechanical soft, solids, tube feeding)_____
Does your child have any diet restrictions? [ ] Yes [ ] No
If so, describe _____

General:
What are your goals? _____
_____
Additional comments? _____
_____
_____ _____
Signature Date

Questionnaire adapted from Occupational Therapy Associates in Watertown, MA

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Patient Consent to Treatment

I hereby authorize Tender Ones Therapy Services, Inc. to evaluate and treat_____ for pediatric Physical Therapy / Occupational Therapy / Speech Therapy.

_____ _____

Parent or Legal Guardian Signature Date of signature

Acknowledgement of Receipt of Notice of Privacy Practices

I have been issued a copy of Tender Ones Therapy Services, Inc. Notice of Privacy Practices. If there are questions regarding this Notice I understand that I may contact the Privacy officer, Noreen Zulaica at (770) 904-6009.

I understand that the client's protected health information may be used and disclosed to carry out treatment, payment or healthcare operations. For a more complete description of the potential uses and disclosures of protected health information please refer to our companies Notice of Privacy Practices of Protected Health Information. You have the right to review the Notice of Privacy Practices prior to signing this consent.

Please note that you have the right to request that Tender Ones Therapy Services, Inc. restrict how your protected health information is used or disclosed to carry out treatment, payment or health care operations. It should be noted that the provider is not required to agree to requested restrictions, however if the provider agrees to a requested restriction, the restriction is binding on the provider.

You have the right to revoke your consent in writing, except to the extent that the provider has taken action in reliance on it.

_____ _____

Parent of Legal Guardian Signature Date of Signature

Photograph / Video Consent & Release Form

I hereby authorize Tender Ones Therapy Services, Inc. to use the photographs and/ or video taken of myself or my minor child during therapy sessions for educational, informational and promotional materials including website production.

Parent or Guardian Signature: _____Date: _____

Minor's Name: _____ DOB: _____

OR

I decline authorization for Tender Ones Therapy Services, Inc. to use the photographs and/ or video taken of myself or my minor child during therapy sessions for educational, informational and promotional materials including website production.

Parent or Guardian Signature: _____Date: _____

Minor's Name: _____DOB: _____

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Insurance/ Guarantor Information

Child's Name:_____Birthdate:_____

Primary Insurance Name: _____ Insurance Phone #: _____
Insurance claims Address: _____
Policy #: _____ Group Name: _____Group #: _____
Policy Holder Name: _____ Birthdate: _____Effective date: _____

Secondary Insurance Name: _____ Insurance Phone #: _____
Insurance claims Address: _____
Policy #: _____ Group Name: _____Group #: _____
Policy Holder Name: _____ Birthdate: _____Effective date: _____

Medicaid #: _____ PeachCare #: _____

Billing Policies / Assignment of Benefits

1. We will bill your insurance as a courtesy to you. However, it is your responsibility to assist in the prompt receipt of payment from your insurance company.
2. **It is the individual patient/parent/guarantor responsibility to understand the coverage and limitations of their insurance policy. This includes keeping track of the number of visits allowed each year for each discipline. If your visits are exhausted prior to the end of the year you will be responsible for privately paying for any non covered services.**
3. Parent or legal guardians are responsible for payment of services if insurance or secondary plan coverage is terminated.
4. Please inform Tender Ones Therapy Services, Inc. of any changes in insurance or Medicaid. Failure to notify us on changes may result in parent or legal guardian being responsible for payment.
5. Any invoice that is not paid within 30 days will receive a phone call or follow-up invoice. Any invoice not paid within 90 days will be turned over to our collection agency.
6. If you need any special assistance to pay your portion of therapy charges, please don't hesitate to call our office. We will be happy to develop a plan to assist you.
7. We require a 24 hour notice for patient cancellations. If we are not notified you will be charged a $ 25 cancellation/No show fee. This is not billable to insurance.

I understand and accept the billing policies and procedures listed above and authorize payment of medical benefits and /or government benefits to Tender Ones Therapy Services, Inc.

_____ _____
Parent or legal guardian Date of signature

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Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. This notice will be in effect until we replace it or you withdraw it. Protected health information is the information we obtain and create in providing services to you. This would include demographic information that would identify you and information that relates to your physical or mental health condition and related healthcare services. Examples include documentation of your evaluation, progress notes, diagnosis and treatment plan.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For Example:

Treatment: We may use or disclose your health information when discussing your plan of care with your physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. These include quality assessment, clinical guideline development, medical review, legal services, and training.

Your Authorization: In addition to our use of your health information for treatment, payment of healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time.

Communication with Family: Using our best judgement we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment of such care if you do not object or in an emergency.

Notification: We may use or disclose your protected health information to notify, or assist in notifying a family member or other person responsible for your care, about your location, and about your general condition, or death.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Marketing Health Related Services: We will not use your health information for marketing communications with out your prior authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voicemail.

Website: If we maintain a website that provides information about our company this notice will be available on the website and available in written form.

YOUR HEALTH INFORMATION RIGHTS

Access: You have the right to inspect and copy your health record and billing record. You must make a request in writing to obtain access to your health information and send it to Tender Ones Therapy Services, Inc. 2089 Teron Trace Suite 120 Dacula, GA 30019

Disclosure: You have the right to receive a list of instances in which we have disclosed your health information for purposes, other than treatment, payment or healthcare operations.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make this request in writing.

Amendment: You have the right to request in writing that we amend your health information. We are not required to make such amendments.

QUESTION AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you have questions, would like more information regarding our privacy practices or want to report a concern regarding the handling of your information, you may contact Noreen Zulaica at (770) 904-6009.

If you feel that your privacy rights have been violated, you may file a written complaint to our company. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.