WELCOME

Tender Ones Therapy Services, Inc. offers:

Physical Therapy, Occupational Therapy, Speech Therapy, Intensive Therapy Programs, Aquatic Therapy

Required signatures: Insurance requires your consent for us to treat and bill your insurance please sign where it is indicated on the following forms and return to the front office staff.

Prescriptions: Even though some insurance does not require referrals our company does require a referral/prescription for therapy from the primary care physician of your child. Including your physician in the treatment plan of your child is important for coordination of services for your child.

Recommendation of Services: If the therapist recommends services they will send the evaluation and plan of care to the physician to be signed off by them. We will schedule appointments immediately is we do not require authorization from insurance. If insurance requires authorization then we will schedule after approval is given.

Documentation: Therapists are required to maintain documentation on your child. This will include an Initial Evaluation, a Plan of Care and daily treatment progress notes. The Plan of Care is updated every six months and standardized testing is done yearly. Your child's therapist is interested in your goals for your child, please discuss these with them.

Attendance: In order to maximize effectiveness of therapy it is important for your child to attend all scheduled appointments. 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.

Parents/siblings: 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**. For the safety of your child and all others siblings are welcome in the waiting area and should not enter the gym area or be on any equipment. If a parent is observing therapy and must keep a young sibling with them we ask that the sibling is kept occupied quietly and not allowed to roam in the room.**

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:_____

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TENDER ONES
THERAPY SERVICES
TOTS
www.tenderones.com

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: ( )_____
Caregiver's Name:_____Relationship: _____
Employer: _____Phone: ( )_____

Name of emergency contact:_____
Relationship to child:_____ Phone: ( )_____
Primary Physician:_____Phone: (___) _____
Referring Physician:_____Phone: (___) _____

Diagnosis: _____

Please list all medications and vitamins/supplements: _____
_____
Please list all allergies: _____
_____
Does the child have a history of seizures? □ Yes □ No
Has your child ever had a swallowing study or a history of aspiration? □ Yes □ No
If yes, what were the results? _____
_____

Caregiver Concerns

1. Why has your child been referred to TOTS? Please discuss any concerns/problems:

_____
_____

2. What are your goals for your child's current episode of care/therapy program? (Please be as specific as possible and consider what would success look like to you.)

_____
_____

Educational Information

1. Does your child currently attend school/daycare: □ Yes □ No
   Name of School/Daycare: _____
   Grade Level: _____

2. Does your child have an **IEP, IFSP, or 504 plan**? □ Yes □ No
   If you answered yes, please provide a copy for our records. We will be unable to treat your child without this information on file.

3. Does your child receive any special help or therapy at school? □ Yes □ No
   If yes, check all that apply:
   □ PT
   □ OT
   □ ST
   □ Vision services
   □ Pull out/Resource services
   □ Classroom or testing accommodations
   □ Behavior Plan
   □ Smaller Class
   □ Self-contained classroom
   □ Other:_____

Additional Medical Providers

1. Has your child ever been seen by any of the following specialists (check all that apply)?
   □ Neurologist
   □ Oncologist
   □ Cardiologist
   □ Pulmonologist
   □ ENT
   □ Allergist
   □ Orthotist
   □ Orthopaedist
   □ Gastroenterologist

Please list the provider, specialty, and date of last visit: _____
_____

2. Is there any family history of mental health issues? □ Yes □ No

3. Does your child have a history of any mental health issues? □ Yes □ No
   If yes, please specify: _____

4. Mental Health Provider(s):
   □ Psychologist
   □ Psychiatrist
   □ Counselor
   Please list the provider(s), specialty, and date of last visit:

_____
_____

5. Is your child receiving any private or other therapy services (OT, PT, ST, etc)?
   □ Yes □ No If yes, please specify:

Family Information & Social Participation:

1. What languages are spoken at home? □ English □ Spanish □ Other _____
2. What language does your child understand and/or speak the best?_____
3. Please list members of the household in which the child lives, including the individual filling out this form:

Name Relationship Age

_____

_____

4. Do you have concerns about your child's ability to play alone or with others? □ Yes □ No
   Additional information: _____
5. Does your child's behavior limit the ability to go to places or participate in activities in the community, including the grocery store, restaurants, etc? □ Yes □ No
   Additional information:_____
6. Does your child tantrum or melt-down often? □ Yes □ No
   If yes, what best helps your child to calm? _____
7. Is your child frustrated easily? □ Yes □ No
8. Does your child have a history of hurting herself/himself or others? □ Yes □ No

BIRTH AND DEVELOPMENTAL HISTORY:

Before Birth:

1. Did mother experience any (check all that apply):
   □ Illnesses
   □ Injuries
   □ Fainting spells
   □ Bleeding
   □ Anemia
   □ Operations
   □ Bed rest
   □ Stress
   □ Gestational Diabetes
   □ Diabetes
   □ Other_____
   Additional information: _____
2. Were any drugs or medication taken during pregnancy? □ Yes □ No
   If yes, please specify:_____

Delivery:

1. Was the pregnancy full term? □ Yes □ No
   If no, please specify gestational age and weight at delivery: _____
2. Delivery was (please check):
   □ Breech
   □ Vaginal
   □ Planned C-section
   □ Emergency C-section
3. Was labor induced? □ Yes □ No
4. Were forceps used? □ Yes □ No
5. Complications with delivery? □ Yes □ No

If yes, please specify:_____

Birth:

1. Was your child considered to have low birth weight? □ Yes □ No
   If yes, please specify:_____ _____
2. Were there complications such as (check any that apply):
   □ Cyanosis
   □ Jaundice
   □ Congenital defects
   □ Scars or bruises
3. Was there a need for (check any that apply):
   □ Oxygen
   □ Transfusions
   □ Tube feedings
4. Were there any feeding difficulties? □ Yes □ No
   If yes, please specify: _____
5. Was your child bottle fed? □ Yes □ No
6. Was your child breast fed? □ Yes □ No
7. Did your child have problems sucking/latching on? □ Yes □ No
8. Did your physician suggest follow-up with any specialists? □ Yes □ No
   If yes, please specify: _____

Medical History:

1. Is your child up-to-date with immunizations? □ Yes □ No
2. Has your child had any of the following (please check all that apply):
   □ Meningitis
   □ High Fevers
   □ Diabetes
   □ Lung issues
   □ Bronchitis
   □ Pneumonia
   □ Heart trouble
   □ Seizures
   □ Allergies
   □ Tuberculosis
   □ Physical Injuries
   □ Asthma
   □ Chronic Ear Infections
   □ Ear tubes
   □ Cancer
   □ Headaches
   □ Reflux
   □ Other
   Additional information: _____
3. Has your child ever been hospitalized? □ Yes □ No
   If yes, please specify: _____
4. Has your child had any surgeries? □ Yes □ No
   If yes, please specify: _____
5. Is there a family history of seizures? □ Yes □ No

Vision & Hearing

1. Has your child had an eye evaluation? □ Yes □ No

If yes, by whom & date of evaluation: _____

2. Does your child wear glasses or contacts? □ Yes □ No
3. Has your child had a hearing evaluation by an audiologist? □ Yes □ No
   Date & Results: _____

Developmental History:

1. Is there a family history of speech, motor or cognitive delays? □ Yes □ No
2. Overall, how would you describe your child's development as compared to other children of the same age?

   □ Faster
   □ Slower
   □ Same as
3. How would you describe your child's tolerance for pain as compared to other children of the same age?
   □ Greater than
   □ Less than
   □ Same as

Motor Development:

1. At what age did your child:
   Roll over both ways?_____
   Sit alone?_____
   Crawl?_____
   Pull to stand? _____ Walk independently? _____

Speech & Language:

1. At what age did your child:
   Say first words?_____
   Use 2-word combinations?_____
   Use short sentences? _____
2. Does your child understand what you say to him/her? □ Yes □ No
3. How does your child currently communicate (check all that apply)?
   □ Gestures/Pointing
   □ Single words
   □ Phrases
   □ Sentences
4. Does your child have difficulty with producing specific sounds? □ Yes □ No
   If yes, please specify: _____

Feeding/Swallowing:

1. Do you have concerns regarding how your child eats or swallows? □ Yes □ No
2. Does your child eat a variety of foods? □ Yes □ No
3. Does your child have any food allergies? □ Yes □ No
   If yes, please specify: _____

Sensory-Motor Development:

1. My child seems to be very sensitive to:
   □ Sounds
   □ Touch
   □ Vision
   □ Movement
   □ Taste
   □ Smell
   □ Does not apply

2. My child doesn't seem to notice:
   □ Sounds
   □ Touch
   □ Vision
   □ Movement
   □ Taste
   □ Smell
   □ Does not apply
3. My child often has trouble learning new movements? □ Yes □ No
4. Does your child tend to be clumsy and have balance/coordination problems? □ Yes □ No
5. Does your child appear to enjoy falling or crashing into things? □ Yes □ No
6. My child prefers:
   □ Bright light
   □ Dark
   □ No preference
7. My child prefers:
   □ Strong smells
   □ Avoids smells
   □ No preference
8. Does your child startle easily? □ Yes □ No
9. Did your child soothe to swaddling as an infant? □ Yes □ No

Tender Ones Therapy Services, Inc.

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 <u>authorize</u> 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 NO PHOTOS

I <u>decline</u> 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: _____

Tender Ones Therapy Services, Inc. **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

Tender Ones Therapy Services, Inc.

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.