Intensive Therapy Program

Information Packet
Thank you for requesting information from Tender Ones Therapy Services, Inc. regarding Pediatric Intensive Therapy and Suit Therapy.

Enclosed please find information regarding T.O.T.S., the TheraSuit, a registration form, parent references and information regarding price and billing.

There is a Letter of Medical clearance that you may provide to your physician. They may sign this form or they may write a prescription for the Intensive Therapy program. They must also state whether the child’s hips are cleared to use the Therasuit. Children with more than 40 degrees subluxation of their hips should not wear the Therasuit. Children who are unable to wear the Therasuit still benefit tremendously by participating in the Intensive Therapy Program.

Our program is typically 3 hours per day for 2 or 3 weeks. We will work with the needs of your child and family to schedule the most appropriate session.

Please inform us as soon as possible which session you would like to attend.

Please visit our website www.tenderones.com for more information.
INTENSIVE THERAPY PAYMENT AND REFUND POLICY

Please read through this information thoroughly. It has been compiled to assist you in payment of your child’s Intensive Therapy Session.

OUR THERAPISTS

Our company provides traditional therapy and Intensive Therapy programs. All intervention is provided by experienced Physical Therapists, Occupational Therapists and Speech Therapists that are licensed in the state of Georgia in their area of specialty.

PRICE

Our billing price for therapy is $200.00 per hour. We provide a discount of $80.00 per hour to those families that are paying at the time that services are rendered and if we are not billing insurance. Therefore the hourly price would be adjusted to $120.00 per hour.

A traditional three week session of Intensive Therapy consists of forty five hours of therapy and is $5,400. (The discounted price of $120/hour if paying at the time of service) This consists of three hours of therapy per day, five days per week for three weeks. The three hours of therapy is provided by a Physical Therapist.

You have the option to have a two week session if this better fits your family’s needs. The price will be pro-rated on an hourly basis. We will customize your child’s session to meet their individual needs and goals. You also have the option of adding Occupational Therapy and Speech Therapy to their program. This is available on a daily basis or two to three days per week.

Please contact us with any questions on how to customize your child’s treatment program.

DEPOSIT

A $1000.00 deposit is required to reserve your child’s session. Placement will not be reserved until a deposit is received. The remaining balance is due two weeks prior to the beginning of the session.

If for some reason you are not able to attend the original session reserved, the deposit will be credited to any available session.

REFUND AND CANCELLATION POLICY

After the deposit and/or full payment has been made, a refund will be made within ninety days for the following reasons:

1) Your child does not meet the criteria to participate in our Intensive Therapy Program
2) Your child’s physician will not authorize participation in the program due to medical reasons. A letter from your child’s physician is required to process the refund.

Cancellations for any reason other than those listed above will result in the deposit or full payment being applied to another session within one calendar year. These funds will otherwise be forfeited after one calendar year from receipt.
PRIVATE INSURANCE

We are in-network with BC/BS, Aetna, Cigna, Humana, UHC and Georgia Medicaid. If we are billing private insurance we require the deposit to hold your child’s session. This is so we know you have a good faith intention of attending. This will be refunded to you after the claims have been processed and if you do not have a co-payment or co-insurance. Otherwise the deposit will be credited toward any portion of the claim that is your responsibility. If your co-payment/co-insurance is larger than the $1000 deposit you will be billed for the balance that is your responsibility. If it is less than the $1000 deposit then you will be refunded the difference.

Please realize that most insurance companies have limitations on how many sessions of therapy they will cover each year. Clarify your benefits so that if we do bill your insurance you will still have additional sessions to last the remainder of the year.

It has been our experience that parents who request a case manager through their insurance are more likely to be reimbursed for the Intensive Therapy Program. You should contact your insurance company at least three months prior to attending the Intensive Therapy Program if possible. This allows time for you to submit documentation and get approval from your insurance. We will bill your out of network insurance if they have sent us a contract prior to the Intensive Therapy Program stating how much they will cover and if we have agreed to this arrangement.

GEORGIA MEDICAID

Georgia Medicaid will cover two hours of Physical Therapy and two hours of Occupational Therapy each month without prior authorization. Prior authorization requests require prescriptions, evaluations and notes to be submitted the preceding month from when therapy will be provided. If your child is receiving therapy from a provider it is best that their therapist write a new plan of care recommending an intensive therapy session. We are happy to discuss with the therapist specific information to include in this plan of care in order to request prior authorization from Medicaid to reimburse for intensive therapy programs. We can not bill Medicaid from another state.

ILLNESS

If your child becomes ill during a session and misses one to three days, we will do our best to make up the missed hours if possible. If a child’s illness results in four or more days of missed treatments, these treatments will either be re-scheduled or a credit will be applied to the child’s next Intensive Therapy Session. Any other reasons for a caregiver canceling a treatment will not result in rescheduling or a refund.

For the well being of other patients and our therapists please be conscientious when your child is not feeling well. Please do not bring your child to therapy if they have the following:

- Any fever over 99 degrees
- Green or yellow runny nose
- Vomiting or diarrhea due to illness
- Breathing difficulty
- Coughing fits / coughing up mucous
- Any infectious illness such as a rash, impetigo, pink eye, chicken pox, etc.
- Ring worm
EMERGENCIES

If your child becomes ill during the treatment session, we will discuss this with the parent / guardian. If there is an emergency situation, we will call 911 and we will contact the parent / guardian if they are not present. If an ambulance is called and the EMT decide that the child should be taken to the ER the child will be taken to Gwinnett Medical Center (15 minute drive) unless the parent or EMT decide that they be taken to Children’s Healthcare of Atlanta (30-45 minute drive).

If you plan on leaving our office at anytime while your child is present for therapy please be sure to leave a cell phone number so that we can contact you.

ACKNOWLEDGEMENT OF INFORMATION

I have read and understand the above information regarding price/ insurance billing/ refunds /cancellations and sickness. I would like to reserve a session of Intensive Therapy for my child.

_____________________________________________________________ Date_________________

RESERVATION

My preferred month to attend is __________,if unavailable my second preference is _________________

I would like a 2 week session __________ (Total of 30 hours of Therapy - $ 3,600.00)

I would like a 3 week session __________ (Total of 45 hours of Therapy - $ 5,400.00)

I would like to customize my child’s session and include Occupational Therapy ________ day per week and Speech Therapy ____________days per week.

Other___________________________________________________________

PAYMENT

My child’s session will be paid in full by: (Please initial)

___________ Check / Money order/ Mastercard / Visa. I have enclosed my $1000 deposit to hold my child’s session.

___________ I have Private Insurance and would like for T.O.T. S to bill my insurance. I have enclosed my $1000 deposit to hold my child’s session.

___________ My child has Georgia Medicaid and I would like for T.O.T.S to bill 2 hours of PT / OT (circle) to Medicaid. I have enclosed my $1000 deposit to hold my child’s session.

___________ I have discussed other arrangements with T.O.T.S
Recommendation for Intensive Physical Therapy Program:

Children with disabilities require repetition of an activity multiple times before solidifying a skill or movement into their typical day. Though the majority of children will progress with the traditional model of therapy of one time per week, progress is often slow. An hour of therapy time is not often adequate to address all the areas of limitations that a child may present with. The hour must be broken down into time spent on strengthening, balance activities, endurance activities and functional skills. By participating in an Intensive Therapy Program the child benefits from the high level of repetition and time that is allotted in all areas of concern. From my experience children tolerate this program very well.

The Intensive Therapy Program consists of 3 hours of Physical Therapy and 1 hour of Occupational Therapy per day, five days per week for 3 weeks. A typical session begins with 10 minutes on hot packs to prepare the muscles for stretching and strengthening. Massage and stretching to the extremities is then provided. This then progresses to resistive exercises to increase active movement, muscle strength and endurance. Floor activities are then worked on for attainment and stability in various positions. The program then progresses to utilizing our unique Universal Exercise Unit. This provides support to the child in various positions including sitting and standing utilizing bungee cords and a supportive belt that teaches balance and control in a dynamic environment. Children then participate in Partial Weight Bearing Gait Therapy over a treadmill. This allows the child to be safely supported and assisted walking over a treadmill. The treadmill program helps to train reciprocal movement and endurance for walking over level ground. These walking skills are then practiced using appropriate assistive devices over level ground and on elevations. Children will also then receive an additional hour of Occupational Therapy to solidify vestibular, feeding and fine motor skills. Parents are strongly encouraged to be present during their child’s therapy sessions and actively participate in the session with their child. We believe in educating the parents on the necessary skills to help care for their special needs child in order to continue the progress that their child attains during the Intensive Therapy Program.

Families are provided with a detailed exercise book that includes actual pictures of their child in various positions and activities that need to be part of their home exercise routine after completion of the program. Skills need to be reinforced in the home and through formal Physical Therapy and Occupational Therapy for a child to continue to progress their functional skills.

Our Intensive Therapy Program consists of 3 hours of Physical Therapy and 1 hour of Occupational Therapy each day for 5 days per week for 3 weeks. This is a combined total of 60 hours of Therapy (45 of PT and 15 of OT) over 3 weeks. Therapy is billed at $200 per hour but private paying patients are offered a discount and billed at $120 per hour. The total cost of the session is $7,200 for 60 hours of therapy at $120 per hour. Modifications to the program are available. OT does not need to be part of the program if not requested. Also, the program is available as a two week session if that better suits the needs of the child. The price of the program is adjusted according to modifications requested.

Please call me if you have any other questions regarding our Intensive Therapy Program.

Tender Ones Therapy Services, Inc.

Office: (770) 904-6009
Fax: (770) 904-2357
Letter of Medical Clearance for Pediatric Intensive Therapy

Patient’s name: _____________________________________ DOB: ____________

Diagnosis: _____________________________________________________________

The program consists of hot packs, massage, intensive exercises causing increased heart rate and respirations.

In order to be cleared to use the Therasuit we require a written hip x-ray report no more than 6 months old or a prescription from the Orthopedist stating that the child’s hips are intact with less than 40 degrees subluxation and the child may wear the Therasuit.

The Therasuit causes increased weight bearing throughout the joints of the body anywhere from 10-30 pounds. The Therasuit is a soft orthosis that is comprised of a hat, vest, shorts, kneepads and shoes that are connected with rubber cords to correctly align the body.

Please either sign below authorizing your patient to participate in an Intensive Therapy Program or provide an original prescription.

I authorize the above patient to participate in an Intensive Therapy program that will consist of: (Please Circle)

- Physical Therapy 3 Hours/day for 5 days for 2 weeks
- Physical Therapy 3 Hours/day for 5 days for 3 weeks
- Occupational Therapy 1 Hour/day for 5 days for 2 weeks
- Occupational Therapy 1 Hour/day for 5 days for 3 weeks

Physician’s Signature: ___________________________ Date: ____________

This child’s hips are intact and/or have less than 40 degrees subluxation. I authorize that they may wear the Therasuit:

Physician’s Signature: ___________________________ Date: ____________

This child has more than 40 degrees subluxation of one or both of their hips and/or I do not authorize use of the Therasuit.

Physician’s Signature: ___________________________ Date: ____________
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 disciplines:
(Note: please provide the office with any previous evaluations):

<table>
<thead>
<tr>
<th>Type</th>
<th>Evaluation Date</th>
<th>Dates of Therapy</th>
<th>Professionals Name /Company name</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT</td>
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<td>OT</td>
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<td>Speech</td>
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<td>Vision</td>
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<td>Hearing</td>
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</table>

**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)

<table>
<thead>
<tr>
<th>Roll Over</th>
<th>Walk</th>
<th>Say words</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chew solid food</td>
<td>Say sentences</td>
</tr>
<tr>
<td>Crawl</td>
<td>Drink from a cup</td>
<td>Babble</td>
</tr>
</tbody>
</table>

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
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

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

Does your child…

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

If you would like to speak with a parent whose child has completed the Intensive Therapy Program, please feel free to contact one of the parents listed below:

Anna Marie Champion 770-561-5950 Child has attended 3 times
(Georgia)

Brandi Helvey 678-758-7498 Child has attended 4 times
(Georgia)

Joni Berry 706-213-8576 Child has attended 1 time
(Georgia)

Kim Buffington 770-318-3068 Child has attended 3 times
(Georgia)

Melanie Metzger 770-992-8747 Child has attended 4 times
(Georgia)

Stetson Hoffman 615-595-0909 Children attended 4 times
(Tennessee)
I. TheraSuit™

In 2002 a device called TheraSuit™ (U.S. patent pending) was designed by Richard and Izabela Koscielny (Physical Therapists, parents of disabled child, and the owners of Therasuit LLC company). TheraSuit™ is manufactured, imported and distributed by Therasuit LLC. TheraSuit™ is the most recent and sophisticated design yet, but does not require lengthy training or special skills. TheraSuit™ was created to be used by therapists and parents alike, both during therapy time and out of the clinical setting. TheraSuit™ is the only one of these kind of devices in USA registered with FDA and meeting all requirements and regulations. Currently there is about 30 clinic around United States successfully using TheraSuit. There is also hundreds of trained parents using TheraSuit on the daily basis. During last two years hundreds of patients had a chance to receive therapy using our invention. TheraSuit proved to be safe and effective therapeutic and exercise tool.

II. How does the TheraSuit work?

TheraSuit™, thanks to its construction and improvements creates a breathable soft dynamic orthotic. Its major goal is to improve and change proprioception (pressure from the joints, ligaments, muscles), reduce patient's pathological reflexes, restore physiological muscle synergies (proper patterns of movement) and load the entire body with weight (process similar to a reaction of our muscles to the gravitational forces acting up us for 24 hours).

All of the above normalizes afferent vestibulo-proprioceptive input (information arriving to the vestibular system). The vestibular system is a very important center. It processes, integrates and sends back all the information that arrives from muscles, joints, tendons etc. It influences muscle tone, balance and the position of the body in space. The more correct proprioception from the joints, ligaments, muscles, tendons, joint's capsule etc., the more correct alignment. The vicious cycle can be interrupted and incorrect information is replaced by "new" correct information. A patient (child) diagnosed with Cerebral Palsy and other neuro-motor disorders requires hundreds of repetitions of any particular movement. We believe that as individuals, we all have a "magic" number. For example: a baby that is trying to push-off the floor will need to repeat this movement a few hundred times in order to master it. Another one may need either more or less repetitions to learn the same skill. For the Cerebral Palsied child however, this fairly low "magic" number grows to a thousand or more repetitions to learn and master new skills. TheraSuit™ worn over a prolonged time will correct proprioception and accelerate the progress. Thanks to the TheraSuit™ and physical movement (therapy) the skills practiced will become more fluent and require less and less effort. Therefore, TheraSuit™ facilitates the development of new gross and fine motor skills like sitting, standing, walking.
III. **TheraSuit - Indications and Benefits**

**Indications:**
- Cerebral Palsy
- Developmental delays
- Traumatic Brain Injury
- Post stroke (CVA)
- Ataxia
- Athetosis
- Spasticity (increased muscle tone)
- Hypotonia (low muscle tone)

**Benefits:**
- Re-trains central nervous system
- Restores ontogenic development
- Provides external stabilization
- Normalizes muscle tone
- Aligns the body to as close to normal as possible
- Provides dynamic correction
- Normalizes (corrects) gait pattern
- Provides tactile stimulation
- Influences the vestibular system
- Improves balance
- Improves coordination
- Decreases uncontrolled movements in ataxia and athetosis
- Improves body and spatial awareness
- Supports weak muscles
- Provides resistance to strong muscles to further enhance strengthening
- Improves speech production and its fluency through head control and trunk support
- Promotes development of both fine and gross motor skills
- Improves bone density
- Helps to decrease contractures
- Helps improve hip alignment through vertical loading over the hip joint
IV. TheraSuit - Contraindications and Precautions

Contraindications:

- hip subluxation greater than 50%
- severe scoliosis

Precautions:

- heart conditions
- uncontrolled seizure activities
- hip subluxation
- hydrocephalus (VP shunt)
- diabetes
- kidney problems
- high blood pressure