TENDER ONES
THERAPY SERVICES

Intensive Therapy Program

Information Packet

2089 Teron Trace
Suite 120
Dacula, GA 30019

Office:770-904-6009
Fax: 770-904-2357

TENDER ONES
THERAPY SERVICES
T O T S

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 to 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 call our office at 770-904-6009 or visit our website www.tenderones.com for more information.

TENDER ONES
THERAPY SERVICES
T O T S

Intensive 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 up to 3 hours of Physical Therapy, 1 hour of Occupational Therapy and one session of Speech therapy per day, five days per week for 2 or 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. If appropriate children will also then receive an additional hour of Occupational Therapy to solidify vestibular, feeding and fine motor skills. Speech Therapy can also be an additional service if warranted. Both OT and Speech can be provided from one to 5 sessions per week.

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.

Please call for pricing and if you have any other questions regarding our Intensive Therapy Program.

Tender Ones Therapy Services, Inc.

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

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

TENDER ONES
THERAPY SERVICES
T O T S

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

Office: 770-904-6009
Fax: 770-904-2357

Letter of Medical Clearance for wearing Therasuit

Patient's name: _____DOB: _____

Diagnosis: _____

In order to be cleared to use the Therasuit we require a written hip x-ray report no more than 6 months old or this form signed by 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 or your patient to wear the Therasuit.

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 <u>I do not</u> authorize use of the Therasuit.

Physician's Signature: _____Date:_____

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

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

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 one to five 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

We strive to provide exceptional care for your child and this comes from both family and therapist being committed. Please be advised due to the amount of time that our staff commits to providing intensive therapy programs we must enforce a cancellation policy specific to this program.

If you choose to cancel or no show for a day of intensive therapy regardless of reason or notice given you will be charged $75 per day. The only exception to this policy is if we are given over 30 days notice of your plans to cancel.

If we have waived the $1000 deposit for your child to attend an intensive therapy session we must then have a credit card on file that will be charged if you do cancel. Otherwise we will deduct this fee from your deposit.

After the deposit and /or full payment has been made, a refund will be provided to the parent of any excess credit on the account within ninety days after completion of the program or for any of the following conditions:

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.
3) All claims have been paid by insurance
4) All no show/cancellation fees have been applied

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.

GEORIGIA 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 cannot 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. 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.

ACKOWLEDGEMENT 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 perweek 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 ask for authorization from Georgia Medicaid to cover intensive therapy. I have enclosed my $1000 deposit to hold my child's session.

_____I have discussed other arrangements with T.O.T.S

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

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

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: _____

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

Office: 770-904-6009
Fax: 770-904-2357

Insurance/ Guarantor Information

Child's Name:_____Birthdate:_____Age:_____ Sex: □M □F
Address:_____City:_____State:_____ZiP :_____
Mother's Name:_____ Home Phone:_____ Cell Phone: _____
Father's Name:_____Home Phone:_____ Cell Phone: _____

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 #: _____

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. Please inform Tender Ones Therapy Services, Inc. of any changes in private insurance or Medicaid coverage. Failure to notify us on changes may result in parent or legal guardian being responsible for payment.
3. Parent or legal guardians are responsible for payment of services if insurance or secondary plan coverage is terminated.
4. 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.
5. 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.

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
TOTS

Fairfield Inn & Suites

1355 Mall of Georgia
Buford, GA 30519
Contact Shakela Ayton at 678-745-3380
$79 per night with complimentary continental breakfast
6.5 miles to TOTS

Hampton Inn &Suites Braselton (Chateau Elan)

5159 Golf Club Drive
Braselton, GA 30517
770-307-0700
$119 Single/Double Occupancy Standard Room
$149 Single/Double Occupancy Studio
Complimentary Hampton hot breakfast
7.1 miles to TOTS

Springhill Suites by Marriott

3250 Buford Drive
Buford, GA 30519 .
678-714-2150
6.8miles to TOTS
Free Continental breakfast, free local calls, small fridge, microwave, iron / board

Country Inn & Suites

1395 Mall of GA. Blvd.
Buford, GA 30519
770-271-1441
6.4 miles to TOTS
Free full hot breakfast, small fridge, coffee maker, microwave, indoor pool, guest laundry.

Holiday Inn Express
Chateau Elan Lodge
2069 HIGHWAY 211
BRASELTON, GA 30517
770-867-8100
7.3 miles to TOTS
Free breakfast bar, mini fridge, outdoor pool, dry cleaning and laundry pick-up.

* These rates may change at anytime.*

INFORMATION REGARDING THERASUIT COPIED WITH PERMISSION FROM THERASUIT, LLC

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**