Alabama Pediatric
THERAPY SERVICES

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Welcome to Alabama Pediatric Therapy Services, LLC!

We appreciate the opportunity to work with you and your child. Please read through and complete all paperwork before your arrival. We ask that you please arrive 20 minutes prior to the start of your appointment. We also ask that siblings not attend the evaluation appointment due to the length of the appointment and so as not to distract from any testing that may need to be administered.

Use the checklist below to ensure all necessary forms have been completed and reviewed. After completion of this packet, please sign below and return to Alabama Pediatric Therapy Services at the time of your evaluation.

Thank you for choosing Alabama Pediatric Therapy Services. We look forward to working with you and your family.

This packet includes the following:

- General Info, School Info, Development & General Health Milestones (Pages 2-3)
- Food Permission Info, Video & Picture Release, & Consent to Release Info (Page 4)
- Attendance Policy & Drop Off Policy, Parent Attendance, Sick Policy, Financial Policy, Child Abuse, & Judicial Policies (Pages 5-8) (For your records)

My signature below is confirmation I have read and received all necessary paperwork and I agree to all terms and conditions. I have informed APTS of all necessary information regarding my child's health and give permission to the therapists at APTS to treat my child at their discretion.

I have provided APTS with my insurance information and acknowledge I am financially responsible for all charges not paid by insurance. This also authorizes APTS to release all information necessary to secure the payment of benefits.

Childs Name:_____

Parent/Guardian Signature/Date:_____

I have received and understand APTS Notice of Privacy Policies and Practices.

Parent/Guardian Signature/Date_____

Please fill out the following information in its entirety to the best of your ability to better assist APTS.

General Information

Child's Name: _____

Preferred name to be called: _____

Date of Birth: _____

Address: _____

City: _____State: _____ Zip: _____

Insurance Carrier's DOB: Month: _____/ Day:_____/ Year:_____

Parent/Guardian ___ Biological ___ Adoption ___ Foster Care

Caregiver 1: _____

Caregiver 2: _____

Caregiver 1 Cell: _____ Caregiver 2 Cell: _____

Home Phone: (Primary Caregiver) _____

Parent
Email:_____

Child lives with both parents? _____ Yes _____No

If no, whom? _____

Emergency Contact: _____ Relationship: _____

Phone: _____

How did you first hear about us?

_____Facebook _____Instagram _____Physician _____Friend

_____Family Member _____School _____Internet Search

Referred By: First Name: _____ Last Name: _____

Physician Name: _____

School Information

Name of
School:_____

Current
Grade:_____

Teachers
Name:_____

Academic Concerns:

_____
_____
_____

Does your child currently receive school-based services? _____ No _____ Yes If so, please provide the types of therapy and frequency:

_____
_____

State of Issues/Concerns:

Please state in your own words what do you think the child's issues are, and what you think might have caused it.

_____
_____

When did you first notice these issues/have these concerns?

_____
_____

Medical History

Patient Diagnosis: _____

Please check if your child has had any of the following (and if so, what age):

___ Seizures ___ High fevers ___ Measles ___ Mumps ___Chicken Pox ___ Whooping Cough
___ Tonsillitis ____ Meningitis ___ Diphtheria ___ Croup ___ Pneumonia ___ Asthma
___ Rheumatic fever ____ Tuberculosis ___ Encephalitis ___Sinusitis ___ Thyroid ___Heart Trouble
____ Chronic cold ____ Enlarged glands ____ Frequent ear infections

Please explain any checked items here:

_____
_____

Are immunizations current: _____

Previous Hospitalizations (date, type, length):

_____
_____
__

Orthotics/Braces Used (type, length of use):
_____

Current Medications (name and indication):
_____
_____
__

Does your child have a history of (please circle): Head Injury: Y / N Vision Loss/Correction: Y / N Hearing loss: Y / N Aides: Y / N If answered yes,
explain:_____
_____

ALLERGIES:
_____
_____
__

Epi-Pen Needed: Y / N

Has your child had a hearing and vision screening in the past 12 months?

_____ No _____ Yes If so, did he or she pass? _____

Has your child received any therapy services in the past? ____ Yes ____ No

If so, please provide types of services:
_____
_____

Are there any special precautions or limitations that pertain to therapy (e.g. Physician precautions):
_____
_____

<u>Prenatal/ Birth History</u>

DEVELOPMENTAL HISTORY: Pregnancy/Birth (complications before during and after birth):_____
_____
_____

Full-Term Weeks: _____ Pre-Term/Gestational Weeks _____

Birth Weight: _____

Delivery (please circle): Vaginal Cesarean Breech Feet First

Did your child spend time in the NICU? _____No _____ Yes

If yes, Please specify:
_____

Did your child require special treatment after birth? (i.e., oxygen, jaundice, etc.) _____ No _____ Yes

If yes; Please specify: _____

Illnesses or accidents during pregnancy:
_____

Medications used during pregnancy:
_____

Developmental History

Age when child: (If you can't remember specific times, please indicate if it occurred at the expected time or was delayed)

_____Roll over _____ Sat alone _____ Crawled _____ Stand
_____Walk alone _____ Eat baby food _____ Say 1st words _____ Used cup without lid
_____ Used a straw _____ Combined two words

Does your child choke while eating? _____ No _____ Yes If "yes," on what foods?
_____

Is your child a picky eater? _____ No _____ Yes If "yes," what foods does he/she prefer?
_____

Is there anything else the Therapist should know about your child? (e.g. behaviors, sensitivities, fears):_____
_____
_____
_____

Check the following items that best describe your child.

Visual
_____ Wears glasses
_____ Has a diagnosed visual problem (describe):
_____ Has difficulty finding/ seeing things (shoes in the closet, toy in a toy basket)

Auditory and Language
_____ Has a suspected or diagnosed hearing loss
_____ Limited or absence of gesturing to assist in communication
_____ Excessive talking interferes with listening
_____ Nonverbal; Do they have a form of communication? List/circle the form of communication system (PECS, Sign Language, gestures used, etc.):
If language is not strong, describe the vocalization your child uses:
_____

Oral-Motor and Respiratory Control
_____ Displays poor lip control/ lip closure for eating, drinking, using utensils
_____ Has limited skills with blow toys, whistles, bubbles
_____ Demonstrates poor saliva control (drools)
_____ Chokes easily on liquids or solids. Specify:
_____ Overstuffs mouth with food

_____ Clenches jaw or grinds teeth
_____ Holds breath frequently
_____ Breathes with mouth open/ often has mouth open
_____ Noisy breathing/ snores

Self-care/ Regulation of Body Function

Is your child able to complete these tasks independently (please circle Yes/ No)

Yes or No____ Toileting: bowel and bladder control
Yes or No____ Undressing
Yes or No____ Dressing
Yes or No____ Snaps/ Unsnaps
Yes or No____ Buttons/ Unbuttons
Yes or No____ Zippers pull/ engage/ disengage
Yes or No____ Velcro on/off
Yes or No____ Socks on/off
Yes or No____ Self-feeding (finger foods)
Yes or No____ Uses utensils (circle all that apply: spoon, fork, knife)
Yes or No____ Uses open cup
Yes or No____ Sippy cup
Yes or No____ Uses a straw

Language Development

How well is your child understood by: (i.e., what percentage of the time?)
Mom: _____ Dad:_____ Unfamiliar Adults:_____

Has your child received speech treatment? _____ How long? _____ By whom?
_____

Describe what it's like to have a conversation with your child:
_____
_____

Language(s) spoken at
home:_____

Which are spoken by the
child?_____

Which are understood by the
child?_____

How many words can your child say? (List if fewer than fifteen)
_____
_____

Does your child have difficulty following directions? (Describe)
_____

What is the primary method(s) your child uses for letting you know what she/he wants? Please check.
____ Looking at objects ____ pointing at objects ____ gestures
____ Crying ____ vocalizing/ grunting ____ physical manipulation

____ Single words ____ 2-3 word combinations ____ sentences

Which of the following best describes your child's speech? Check all that apply.
_____ easy to understand _____ difficult for parents to understand
_____ difficult for others to understand _____ almost never understood by others
_____ different from other children of the same age

Which of the following best describes your child's reaction to his/her speech?
_____ Is easily frustrated when not understood
_____ Has been teased about their speech
_____ Does not seem aware of speech/communication problem
_____ Tries to say sounds or words more clearly when asked
_____ Is successful in saying sounds or words more clearly when he/she tries

Play Behaviors

Which of the following describes the type of play your child likes to engage in the most often? Check all that apply.
_____ Putting toys in mouth _____ Banging toys together _____ Throwing toys
_____ Shaking toys _____ Pushing/pulling toys _____ Role playing
_____ Acting out familiar routines _____ Games with rules _____ Rough/ tumble play
_____ Looking at books

What is the length of time your child can stay playing one activity?
_____

What activity seems to hold your child's attention for the longest period of time?
_____

Which activities seem to hold your child's attention for the shortest period of time?
_____

Additional comments:

Please provide any other information that you would like to share about your child. Such as your goal(s) for therapy.

_____

_____

_____

_____

_____

Food Permission/Dietary Information

Please list any allergies or sensitivities your child may have, including food, non-food, and/or latex:

_____

_____

_____

_____

Please complete the following to allow your child to participate in snack activities.

_____ My child may participate in snacks and has no diet restrictions.

_____ My child may participate in snacks if diet restrictions are observed.

Diet
Restrictions:_____

_____ My child should not participate in snack time, unless the snack is provided by myself.

Video and Picture Release

_____ I give permission for my child's picture/video to be used by Alabama Pediatric Therapy Services, LLC. for the purpose of training other professionals or paraprofessionals.
_____ I give permission for my child's picture/video to be used by Alabama Pediatric Therapy Services, LLC. for marketing/publicity.
_____ I do not wish my child's picture/video to be used for any purpose other than training his/her specific clinical team.

Child's Name: _____

Consent to Release/Receive Medical Information

We encourage you to provide us with contact information of other professional(s) working with your child, so we may coordinate care. *I agree to let Alabama Pediatric Therapy Services, LLC. share and receive information from other agencies (organizations) about my child so services can be coordinated and optimized for my child's benefit. The following organizations are included in this release:*

Medical Professionals:

_____

_____

_____

_____

Schools/Teachers:_____

_____

_____

_____

Other:_____

Parent Signature: _____

Hold Harmless Agreement Relating to Facilities and Gym Equipment

At Alabama Pediatric Therapy Services, LLC, our goal is to improve the quality of everyday life for young patients with developmental delays and special needs. In many cases the use of gym equipment can be helpful for increasing strength, endurance, range of motion, balance, control of movement, and coordination. The use of gym equipment and overall facilities can help promote meaningful play and demonstrate how to incorporate equipment into children's everyday lifestyles.

Our gym equipment is thoroughly maintained, and inspections take place on a routine basis; however, APTS cannot guarantee that you or your child(ren) will not become injured while using our facilities and/or gym equipment.

By signing this agreement, I acknowledge and voluntarily assume the risk that my child(ren) and I may encounter while utilizing APTS facilities and gym equipment and that such use may result in personal injury, illness, permanent disability, and death. I understand that the risk of injury while at APTS may result from the actions, omissions, or negligence of myself and others, including, but not limited to, APTS employees, volunteers, and patients and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s attendance at APTS. On behalf, and on behalf of my child(ren), I hereby release, covenant not to sue, discharge, and hold harmless APTS, its employees, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto.
I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of APTS, its employees, and representatives, whether an injury is sustained before, during, or after participation in any APTS therapy.

Parent Signature: _____

Date: _____

Print Name of Patient/Guardian: _____

Patient Name: _____

PLEASE KEEP FOR YOUR RECORDS

Cancellation and Sick Policy

Attendance policy: In order to maintain professional courtesy for our therapists we ask that cancellations be made 24 hours prior to scheduled appointment. We encourage parents and caregivers to reschedule missed or cancelled sessions to maintain consistent treatment optimizing your child's progress. It is APTS's policy to remove clients from the schedule following 2 consecutive no-show treatment sessions.

Sick policy: For protection of the therapists and other clients, please reschedule your child's treatment session(s) if they are in a contagious stage of any illness or not currently on medication for their illness. We require clients to be vomit and fever free for 24 hours prior to returning to treatment sessions. If your child does not attend school or daycare that day due to illness, please cancel and reschedule treatment sessions.

Drop Off Policy

Parents are expected to be on time for arrival and pick up of their children for appointments .Children that arrive 10 or more minutes late for an appointment will be rescheduled as appointments are available. We request you be available 10 minutes PRIOR to the end of your child's therapy session so the staff may talk with you and educate you on any home programming needs. If you are unavailable 10 minutes prior to the end of the treatment session, or arrive late to pick up your child, the staff may not be able to address your home program needs or answer any questions. **You may leave the premises of APTS during treatment sessions as long as you can be reached by cell phone at all times. If you do not have a cell phone we require you remain on the premises.

Sibling/Parent Attendance Policy

It is the policy of APTS that siblings will not be allowed in the treatment area during treatment sessions. Siblings: Parents, please be aware of the client's siblings or other children's whereabouts and actions while they are in the waiting room of the clinic. APTS cannot be responsible for accidents to siblings in the waiting area. We ask that you clean up after your children in the waiting room. We encourage parental involvement, and parents are welcome to observe therapy sessions when appropriate. We request only one parent/caregiver be present at a time during therapy sessions. If parent/caregiver attendance is a distraction or impacts any child's participation you may be asked to sit out of sight or to wait in the waiting room to optimize the effectiveness of the treatment session. Each therapist will use their discretion to determine if parental attendance is necessary.

Clinic Closures

Alabama Pediatric Therapy Services closes in observation of the following holidays: New Year's Day, Memorial Day, 4th of July, Labor Day, Thanksgiving and the week of Christmas. We are open for all other school closure days, including other holidays and breaks. However, APTS reserves the right to close on other holidays if census is projected to be low. APTS may or may not remain open if the local school districts are closed due to weather, please check our Facebook page or call for updates on any clinic closures.

Financial Policy

Insurance claims will be filed on the next business day by our billing staff. Your insurance company may request certain information directly from you, and it is your responsibility to comply with their requests.

Additionally, your insurance company may request clinical information about your child from APTS. It is our policy to release such information to assist you in the filing of your insurance claims.
Once claims have been processed, it is your responsibility to pay the balance of any uncovered claims and/or any balances unpaid by the insurance company. Your insurance benefits are a contract between you and the insurance carrier; APTS is not a party to that contract. In the event of a denied claim(s), or if APTS is not in network with your insurance plan, APTS will offer a 20% discount for services.

Please make sure we receive a copy of your insurance card and/or ID when you arrive at your first visit and/or if you receive a new card or change insurance plans after your first visit. If you fail to provide this information in a timely manner, you may be responsible for the balance of the claim(s). APTS will file claims with up to two insurance companies on your behalf; you will be responsible for filing any additional claims. APTS staff will verify your insurance coverage before your initial evaluation and can inform you of your child's benefits. This is not a guarantee of benefits or payment. We also strongly encourage you to call your insurance company directly to get an explanation of benefits and to make sure all information is understood and accurate. Some services a patient receives at APTS may be non-covered or deemed not medically necessary by your insurer. Patients may be billed for such services if applicable.

Co-payments and Deductible

All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on the part of APTS staff to collect co-payments from patients can be considered fraud. If you have an insurance co-payment, it will be collected when you check in at each visit.

Methods of Payment

APTS accepts payment by cash or check. A $35.00 service fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to pre-pay all future services in full by cash.

Patient Statements

Unless other arrangements are approved by APTS in writing, all balances are due in full at the time the statement is issued, and are considered past due if not paid within 30 days.

Nonpayment

If your account is past due 90 days or greater, and a payment arrangement has not been made, the account will be sent to collections. Until such balance is paid in full, scheduling and attending therapy sessions will be on hold. Patients may be discharged from services due to non-payment.

Bankruptcy

In the event of bankruptcy, any future appointments would need to be paid at the time of service.

Divorce

In the case of a divorce or separation, both parties may be held responsible for any balances owed.

Credit Balance Refunds

Alabama Pediatric Therapy Services, LLC. will make a good faith effort to capture all accounts which have been overpaid by a patient or insurance carrier and to refund the appropriate party within a reasonable time frame. Refunds will be issued quarterly via company check, payable to the patient or insurance carrier.

Self Pay

In the event a patient does not have health insurance coverage, a 20% cash discount will be applied to therapy services. A minimum of a $50 per therapy copay must be paid at the time of service and APTS will invoice the patient for all remaining charges.

Payment Plan

Payment plans will be considered on a case-by-case basis and must be arranged in advance with APTS billing staff.

Child Abuse

If APTS knows, or has reasonable cause to suspect that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, the law requires such knowledge or suspicion to be reported to the proper authorities.

Legal Proceedings

By law, APTS is required to release information about your child's health information and services received at APTS when requested by subpoena or court order.

"No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, APTS reserves the right to charge a fee of $25.00 for all "No Show" appointments. "No Show" fees will be collected upon next visit. This fee is not covered by insurance and must be paid at your next appointment. Three consecutive cancellations or "No Shows" results in loss of recurring appointment time.

Privacy

After each therapy session, the therapist will update the parent/guardian of the child's progress, concerns, and treatment session. If you do not feel comfortable with them updating you in the lobby, please let the therapist or the front office know, so we can pull you into a private room.

NOTICE OF PRIVACY PRACTICES

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at Alabama Pediatric Therapy Services, LLC. for patients to request to take with them. We must post the Notice in Alabama Pediatric Therapy Services, LLC. in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent

with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in Alabama Pediatric Therapy Services, LLC as discussed above.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. OUR LEGAL DUTY 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. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2016, and will

remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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 to a 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. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or 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. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in

your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or

other similar forms of health information. Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

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. National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances. Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before January 1, 2003. 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 (except in an emergency).

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 your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. 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.