Dear Parent(s)/Guardian(s):

We are excited to be working with you and your child soon. Prior to your child's upcoming appointment, we have several forms we would need for you to complete.

The forms included within this packet include:

- Patient History Form
- Attendance Policy
- Coordination of Care requirement
- Consent to Treat
- Consent for Marketing/Media
- New Patient Information
- Notice of Privacy Practices

Please complete the paperwork **prior** to your scheduled appointment to ensure the therapist has enough time to spend with your child during the scheduled appointment time. You will also receive a short questionnaire from our intake coordinator upon arrival.

During the initial evaluation appointment, you and your child will spend time discussing the reason for your visit, answering therapist's questions and your child may complete testing at the discretion of the therapist. Please make sure your child comes dressed to play in comfortable, easy to move in clothing and sneakers. (No dresses please).

If any questions or concerns arise as you complete these forms, please call do not hesitate to call us. We look forward to seeing you soon!

Sincerely,

Advanced Therapy Solutions, Kids!

ADVANCED therapy SOLUTIONS
serving children and their families
Kids!

Responsible Party Information

Account #	Social Security #	Title	Last Name	First Name	MI

Street Address (Road or Street)	(Apartment Number or Second Address Line)

Zip Code	City	State	Email Address

Home Phone:	Cell Phone:	Name and Cell Phone: (Person Bringing The Patient)

Birthday (*Required)*	Sex (M, F)	Doctor (Full Name)	Name of Practice of Doctor

Marital	Employment	Student	Relationship to Patient
☐M-Married ☐ W-Widowed ☐S-Single ☐D-Divorced ☐ X-Separated	☐ R-Retired ☐ F-Full ☐P-Part ☐ N-None	☐ P-Part ☐ F-Full ☐ N-None	☐Parent ☐Guardian ☐OT-Other

	Employer Name

Employer Street Address (Road or Street)

Zip Code	City	State	Business Phone	Ext

INSURANCE INFORMATION

Primary Insurance Company Name Mailing Address

Insurance Telephone # ID # **Very Important** Group #

Secondary Insurance Company Name Mailing Address

Secondary Telephone # ID # **Very Important** Group #

PATIENT INFORMATION

Social Security #	Title	Last Name	First Name	MI

Birthday (**REQUIRED**)	Sex (M, F)	Relationship to Insured:	Food Allergies or Special Diet:

I authorize the release of any medical or other information necessary to process insurance claims.

Signed Date

I authorize payment of medical benefits directly to this practice for the services rendered.

Signed Date

BENEFIT ASSIGNMENT AND RELEASE OF INFORMATION

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicaid, private insurance and third party payers to Advanced Therapy Solutions. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

- **PLEASE NOTE**: **Benefits provided prior to treatment are only an estimation and not a guarantee of payment.** Benefits are determined at the time claims are processed and are subject to change. It is the patient's responsibility to determine if the estimation of benefits is correct. Advanced Therapy Solutions encourages the patient to call the insurance company to determine correct benefits.

  _____ Initial

CANCELLATION & NO SHOW FEES

We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment. If you do not cancel before the end of the business day PRIOR to your appointment (and there is no acceptable reason) you will be charged a $35.00 fee.

_____ Initial

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. We will submit your claims to your insurance provider and assist you in any way we reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility regardless if your insurance company pays. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

- ATS accepts payments by cash, check, Care Credit, Visa, MasterCard, and debit cards bearing these logos. **Payment is expected at time of service.** If your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.

  _____ Initial

- If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to ATS**.** When you pay by check, you expressly authorize ATS if your check is dishonored or returned for any reason, to electronically debit your account in the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax).

  _____ Initial

- I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

  _____ Initial

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for ATS to furnish medical care and treatment considered necessary and proper in diagnosing or treating his/her physical and mental condition.

_____

Patient/Guardian/Responsible Party Date

_____

Office Representative/Witness Date

NOTICE OF PRIVACY PRACTICES

As part of my health care, **Advanced Therapy Solutions, Inc** (**Advanced Therapy Solutions, INC**) creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among **Advanced Therapy Solutions, INC**'s personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for **Advanced Therapy Solutions, INC** that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that Advanced Therapy Solutions, INC may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand Advanced Therapy Solutions, INC, for Workman's Compensation Cases, will release the minimum necessary PHI/ePHI to your employer, your worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that Advanced Therapy Solutions, INC is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Advanced Therapy Solutions, INC and agree to the liability limitations explained therein.

Signature of patient or legal representative	Date	Relationship to Patient

Printed name of patient

ADVANCED THERAPY SOLUTIONS KIDS

Attendance Policy

1. Please cancel therapy if patient or sibling has presented with any of the following within 24 hours of his/her appointment: fever, diarrhea, vomiting or another contagious illness. Sickness will not be added to the missed attendance percentage.

2. If the appointment can be rescheduled at a mutually convenient time, the cancellation will not be considered a missed visit. This appointment may or may not be with your regular therapist.

3. If your child's attendance rate falls below 75% or 3/4 visits, he/she will be removed from the therapy schedule. In response to excessive tardiness, absences and/or cancellations, a conference will be held. Unusually extenuating circumstances will be taken into consideration.

4. If you arrive late by 15 minutes or more past the scheduled appointment time, your therapist may have been assigned to another patient and your appointment may be cancelled. If you are running later, please call the intake coordinator to determine if you need to reschedule. A consistent pattern of the late arrivals will result in discharge from treatment.

5. Caregivers are required to stay on the premises at the clinic during treatment sessions, unless otherwise approved by the patient's therapist. Caregivers who are approved to leave are required to return 10 minutes before the end of the session. If caregivers abuse this policy, they will be required to stay on the premises.

6. Please help us keep our waiting are clean by picking up toys and games after use and by keeping food and drink use to a minimum.

Regular participation is needed to achieve therapy goals.

Please call our office with any schedule changes. We will be happy to work with you in any way that we can.

_____ _____

Caregiver Signature Date

ADVANCED therapy SOLUTIONS
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Kids!

Coordination of Care Requirement

Due to Medicaid and insurance restrictions, **you are responsible** to notify us if your child is receiving services, including **speech, occupational therapy and physical therapy through another provider.** We must maintain an accurate count of services your child receives to stay in compliance. **Failure to do so may cause termination of services.**

Is your child receiving service from any other providers? Yes___ No___ If yes, please list service type, provider name, and duration and frequency of visits per week:

_____

_____

_____

_____

_____

_____

_____

_____

Consent for Release of Information
For
Marketing/Media Purposes

This form is to provide WRITTEN consent or refusal of permission to photograph you and/or your child.

These photographs, along with your and/or your child's first name and testimonial, MAY be used for the following purposes:

- Printed form on display in our clinic
- Printed form on display during promotional events
- Digital form on educational CDs, in our newsletter, and/or on our website or social media

Patient: _____
(Please use full name here for internal purposes only.)

Parent or Legal Guardian: _____
(Please use full name here for internal purposes only.)

SPECIFIC AUTHORIZATIONS

- I give **Advanced Therapy Solutions** permission to use my name, my child's first *name* only, *photographs* and/or *testimonial* if indicated in printed/digital form.

By signing this form, you are giving **Advanced Therapy Solutions** permission to use and disclose your protected health information in accordance with the directive listed above.

Signature _____ **Date:** _____

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Advanced Therapy Solutions will not refuse to provide treatment.

- I REFUSE/DECLINE **Advanced Therapy Solutions** the use of any of my or my child's information, photographs or any/all media in any form.

Signature _____ **Date:** _____

ADVANCED therapy SOLUTIONS Kids!
serving children and their families

GENERAL INFORMATION for PEDIATRIC HISTORY FORM: AGES 0-3

Date: _____

Child's Name:		**Child's Nickname:**		**Sex:** ☐ Male ☐ Female
Birth Date:		**Medical Diagnosis:**		
Form Completed by:		**Relationship to child:**		

Child lives with:	☐ Father ☐ Mother ☐ Siblings ☐ Other:_____
Parent Name(s):	
Phone Number(s):	☐ Home:_____ ☐ Cell:_____ ☐ Work:_____
Home Address:	
Guardian Name(s): if different than parents	
Guardian Address: if different than parents	

Child's Referring Physician:		**Doctor's Phone #:**	
Reason for Referral:			
Other Physicians/Specialists/Medical Professionals seeing your child:			
Name:		**Specialty:**	
Name:		**Specialty:**	
Name:		**Specialty:**	

FAMILY HISTORY:

Mother & Father Age	Occupation

Name of any Siblings	Age

BIRTH AND DEVELOPMENTAL HISTORY:

Child Birth History: ☐ Adopted (at what age?_____) ☐ Biological ☐ Foster (if so how long in current home?_____)	
Was the pregnancy full term (37+ weeks)? ☐ Yes ☐ No. If no, length of pregnancy was: _____ weeks.	
Type of delivery: ☐ Normal ☐ Breech ☐ Cesarean ☐ Forceps	
Did your child stay in the NICU? ☐ No ☐ Yes. If yes, length of stay was: _____ weeks.	
During pregnancy, did the mother have any complications (ex. Infections, illnesses, injuries, etc?)	
Did your child have any complications during or after birth (ex. Jaundice, transfusions, etc.)?	
Describe any congential defects/concerns.	
Are there any recent changes or stresses in the family home that may affect your child?	

MEDICAL HISTORY:

Please describe any **CHILD-SPECIFIC history** of medical/genetic problems that you feel we should be aware.	
Please describe any **FAMILY-SPECIFIC history** of medical/genetic problems that you feel we should be aware.	

What medications is your child currently taking?

Medication	Purpose	Frequency/Dosage

Has your child had any history of the following? Check Yes or No. If yes, please provide approximate age and description.

Health-Related Problem	Yes	No	If yes, approximate age	Description
Childhood diseases or major illnesses?	☐	☐		
Convulsions, seizures or fainting?	☐	☐		
Hospitalizations/Surgeries?	☐	☐		

Health-Related Problem continued	Yes	No	If yes, approximate age	Description
Serious injury?	☐	☐		
Casts or braces?	☐	☐		
Allergies?	☐	☐		
Dietary restrictions?	☐	☐		
Ear Infections?	☐	☐		
Hearing problems?	☐	☐		
Vision problems?	☐	☐		

Has your child ever had any of the following?

Health-Related Evaluations	Yes	No	If yes, please describe the results.
Psychological evaluation?	☐	☐	
Psychoeducational or learning evaluation?	☐	☐	
Developmental pediatric evaluation?	☐	☐	
Genetic evaluation/testing?	☐	☐	
Neurological evaluation?	☐	☐	
EEG/MRI evaluation?	☐	☐	
Vision screening?	☐	☐	
Hearing screening?	☐	☐	

THERAPY HISTORY: Has your child ever received evaluations or therapy from any of the following services?

Therapy-Related Evaluations	Yes	No	If yes, name of Clinic/Therapist	Dates Received
Occupational Therapy	☐	☐		
Physical Therapy	☐	☐		
Speech Therapy	☐	☐		
ABA Therapy	☐	☐		
BabyNet evaluation	☐	☐		
Other:	☐	☐		

Please describe your child's performance in the following skills.

Neck Motion	Good	Poor	Unable
Turns head to both directions	☐	☐	☐
Keeps head in the middle	☐	☐	☐

Gross Motor Milestones	Good	Poor	Unable
Plays on belly	☐	☐	☐
Plays on back	☐	☐	☐
Rolls over from belly to back	☐	☐	☐
Rolls over from back to belly	☐	☐	☐
Sits alone	☐	☐	☐
Army crawls and/or spins self in a circle on belly	☐	☐	☐
Crawls on all fours	☐	☐	☐
Pulls to stand	☐	☐	☐
Stands unsupported	☐	☐	☐
Walks alone	☐	☐	☐

Does your child have or use any special equipment for daily activities:

☐ Glasses ☐ AFOs ☐ Walker ☐ Crutches ☐ Wheelchair ☐ Other: _____

Fine Motor/Activities of Daily Living	Good	Poor	Unable
Brings hands to mouth	☐	☐	☐
Holds toys in hands	☐	☐	☐
Helps hold bottle/cup	☐	☐	☐
Finger feeds	☐	☐	☐
Eats with utensils	☐	☐	☐
Toilets	☐	☐	☐
Assists in putting on/off basic clothing items	☐	☐	☐
Quality of your child's sleep/naps	☐	☐	☐

FEEDING HISTORY: (You do not complete this section if your child does not portray feeding difficulties)

Does your child demonstrate problems with: ☐ Sucking ☐ Chewing ☐ Choking ☐ Swallowing	
When were **feeding challenges** first noticed?	
Are your child's **food preferences** a concern?	☐ No ☐ Yes, please explain:
Does your child have problems with **liquids**?	☐ No ☐ Yes, please explain:
Please list foods that are **typical to your child's diet.**	

SOCIAL AND PLAY SKILL HISTORY:

Select all that apply to describe your child's personality: ☐ Easy going ☐ Happy ☐ Flexible ☐ Friendly ☐ Loving ☐ Affectionate ☐ Angry ☐ Sensitive ☐ Agitated ☐ Avoidant ☐ Easily Frustrated ☐ Quiet	
Select all that apply to describe your child's interactions/relationships with family and friends: ☐ Happy ☐ Flexible ☐ Loving ☐ Overly affectionate ☐ Loud ☐ Overly talkative ☐ Aggressive ☐ Busy/Chaotic ☐ Domineering ☐ Quiet	
Do you feel your child **plays appropriately** with games/toys and with family and friends?	☐ Yes ☐ No, please explain:
What are your child's **favorite** activities/toys/games?	
What makes your child **smile and laugh**?	
What does your child do when he/she is **angry or frustrated**?	
Please describe any other concerns for **social and play skills.**	

SENSORY HISTORY:

Birth to 6 months: Does your child dislike or react negatively to any of the following? (Check ALL that apply.)

☐ Diaper or clothing changes
☐ Noises (by startling and crying)
☐ Position changes (being passed between people or laid down)
☐ Being held or touched
☐ Bathing

Does your child display any of the following? (Check ALL that apply.)

☐ Difficulty calming when upset
☐ Difficulty falling or staying asleep

Comments:

7 months to 3 years- Please complete the following:

Does your child dislike or react negatively to any of the following? (Check ALL that apply.)

☐ Diaper or clothing changes
☐ Noises (by startling and crying, or covering ears)
☐ Lights
☐ Tastes or textures of food
☐ Being held or touched
☐ Swinging or being tossed in the air
☐ Bathing
☐ Getting hands dirty/sticky
☐ Grooming
☐ Tags in clothing or textures of clothing

Does your child display any of the following? (Check ALL that apply.)

☐ Difficulty calming when upset/excessive crying
☐ Cannot entertain him/herself
☐ Dislikes going to new places
☐ Needs to stick to a routine
☐ Difficulty falling asleep or staying asleep; inconsistent nap schedule
☐ Avoids eye contact
☐ Does not seem to notice loud sounds or respond to name being called
☐ Limited variety of play skills
☐ Difficulty figuring out how to play with new toys
☐ Falls frequently or bumps into things
☐ Dislikes going social gatherings; goes off by himself/herself in social situations
☐ Uses too little or too much force during task completion
☐ Does not respond to pain normally
☐ Tends to act without thinking of safety

Does your child appear to crave an excessive amount of stimulation by doing any of the following? (Check ALL that apply.)

- ☐ Rough-housing
- ☐ Jumping
- ☐ Rocking
- ☐ Spinning
- ☐ Swinging
- ☐ Repetitive movements (hand flapping)
- ☐ Mouthing non-food items (if older than 2 years of age)

Does your child appear sensitive to any of the following? (Check ALL that apply.)

- ☐ Noise
- ☐ Lights
- ☐ Movement
- ☐ Getting hands dirty/sticky
- ☐ Tags in clothing or textures of clothing

Does your child dislike or react negatively to any of the following? (Check ALL that apply.)

- ☐ Diapers or clothing changes
- ☐ Noises
- ☐ Smells
- ☐ Being helped or touched
- ☐ Grooming
- ☐ Bathing or Showering
- ☐ Position changes
- ☐ Swinging or being tossed in the air
- ☐ Tastes or textures of food

Comments:

PARENT/PATIENT GOALS:

Do you have any specific questions about your child that you would like us to address through our assessment?	
Please describe any major concerns and/or goals you have for your child through therapy. Please list in order of importance. 1.	
2.	
3.	
4.	
Please write any additional comments here:	

Thank you for taking the time to complete this form.