PROFESSIONAL THERAPY SERVICES, INC.

1015 Oakhurst Drive
Charleston, WV 25314
TELEPHONE: (304) 345-8101 www.wvpts.com FAX: (304) 345-7386

"PLAYING TO SUCCEED"

Background

Name:_____Birth Date:_____

Age:_____Sex:_____ SSN:_____

Address: _____

City:_____ State:_____ Zip:_____

Contact Information

Mother/Guardian Name:_____Birth Date:_____

Phone Number: cell:_____work:_____other:_____

Father/Guardian Name:_____Birth Date:_____

Phone Number: cell:_____work:_____other:_____

Additional Caregiver Name:_____Birth Date:_____

Phone Number: cell:_____work:_____other:_____

In Case of Emergency Contact:_____Relationship:_____

Phone Number: cell:_____work:_____other:_____

Members in household:_____

Medical History

Pregnancy and Birth: ☐ Healthy/no concerns ☐ Complications/concerns

If complications/concerns, please explain _____

_____

Delivery: ☐ Vaginal ☐ Caesarian

Did the child have problems: ☐ Sucking ☐Swallowing ☐Breathing ☐Feeding

If so, please explain:_____

_____

Medical Diagnosis:

- ☐ Global delay
- ☐ Asthma
- ☐ Autism spectrum disorder
- ☐ Seizure disorder
- ☐ Selective mutism
- ☐ Down syndrome
- ☐ Chronic ear infections
- ☐ Genetic disorders
- ☐ Spina bifida
- ☐ Cerebral palsy
- ☐ Other:_____

_____

_____

Allergies:_____

Medications: _____

Are immunizations up to date? ☐ Yes ☐ No If not, please explain_____

_____

Date of child's last physical examination_____Doctor:_____

Hearing evaluation: ☐ Yes ☐ No Results:_____

By whom:_____ Date:_____

Eye evaluation: ☐Yes ☐ No Results:_____

By whom:_____ Date:_____

Past hospitalizations (with dates as applicable) _____

_____

Past surgeries (with dates as applicable) _____

_____

Past therapy services (with dates as applicable) _____

_____

Has the child received any evaluations for ST/PT/OT at a different location/clinic this calendar year? ☐ Yes ☐ No If so, where:_____

School

Please list any day care centers/school your child has attended (including grade level, city and state): _____

_____

Does your child receive any school-based services? ☐ Yes ☐ No

If yes, please list: _____

Family History

Has anyone on either side of the family had speech, learning, or motor problems or diagnoses?
☐Yes ☐No

If yes, please list concern and relationship to child:_____
_____
_____

_____

Additional Comments

If there are any other factors that you feel would help in evaluating your child that are not covered in this form, please describe below: _____
_____
_____
_____
_____
_____
_____

Parent/Guardian signature:_____

Relationship to child:_____

Date completed: _____

Speech/Language Therapy

(check all that apply)

Speech & Language Concerns

- ☐ Difficult to understand
- ☐ Difficulty producing certain sounds (e.g., R, L, S, TH)
- ☐ Difficulty following directions
- ☐ Limited vocabulary for their age
- ☐ Repeats phrases or scripts from shows/books/etc.
- ☐ Non-speaking or minimally speaking
- ☐ Uses an AAC device or app: _____

Mostly communicates through:

☐ Words ☐ Gestures ☐ Sounds ☐ Guiding others

Social Communication

- ☐ Difficulty interacting with other children or adults
- ☐ Prefers to play alone
- ☐ Does not respond to greetings or social cues
- ☐ Does not take turns in conversation or play

Feeding / Swallowing

- ☐ Gags, coughs, or struggles with certain textures and/or liquids
- ☐ Avoids certain foods:_____
- ☐ Eats fewer than 15 foods
- ☐ Interested in a feeding evaluation- targeting textures, food categories, etc.

Stuttering / Fluency

- ☐ Repeats sounds, syllables, or whole words (i.e. "b-b-ball", "ba-ba-ball", "ball-ball-ball")
- ☐ Stretches out sounds (i.e. "ssssssnake")
- ☐ Gets stuck or blocked when trying to speak (with or without sound)
- ☐ Stuttering is worse when excited, upset or tired
- ☐ Avoids talking due to stuttering
- ☐ Easily frustrated when speaking
- ☐ Talks fast

Voice

- ☐ Sounds hoarse, raspy, breathy, or unusual
- ☐ Frequently loses their voice or talks very loudly
- ☐ Throat clearing

Other areas of concern:_____

_____

_____

_____

_____

_____

_____

Occupational Therapy

(check all that apply)

Concerns with Fine Motor Skills:

- ☐ Handwriting (Please bring a sample of your child's independent work if applicable)
- ☐ Coloring
- ☐ Cutting/scissor skills
- ☐ Hold, handling, or manipulating objects
- ☐ Completing activities that require the use of both hands

Concerns with Sensory Processing:

- ☐ Tolerance of sounds
- ☐ Tolerance with dressing/clothing/tags/seams
- ☐ Limited foods/nutritional concerns
- ☐ Difficulties with outings/transitions
- ☐ Difficulties with tolerance of movement (ex: swinging, navigating playground equipment, etc.)
- ☐ Poor balance (falls easily or bumps into things)
- ☐ Toe walking
- ☐ Awareness of personal space

Concerns with activities of Daily Living:

- ☐ Utensil use (spoon, fork, knife)
- ☐ Falling asleep or staying asleep
- ☐ Dressing/undressing
- ☐ Fasteners (zippers, buttons, shoe-tying)
- ☐ Toileting
- ☐ Bathing/showering tolerance or independence
- ☐ Toothbrushing tolerance or independence
- ☐ Grooming (i.e. nail clipping, haircuts, hair brushing)
- ☐ Opening packages/containers
- ☐ Money skills
- ☐ Simple food preparation
- ☐ Basic cleaning skills

Concerns with Executive Functioning skills

- ☐ Difficulty following multi-step directions
- ☐ Difficulty attending and/or staying focused during activities
- ☐ Seem forgetful or disorganized
- ☐ Has frequent tantrums/meltdowns or intense emotional reactions
- ☐ Difficulty adjusting plans or switching gears
- ☐ Difficulty waiting their turn, interrupting others, thinking before acting, staying still when needed

Other areas of concern:_____

_____

_____

_____

_____

_____

_____

_____

Physical Therapy

(check all that apply)

Primary concerns:

- ☐ Range of motion/flexibility
- ☐ Abnormal muscle tone
- ☐ Strength
- ☐ Not walking
- ☐ Posture
- ☐ Gait
  - ☐ Tip toe
  - ☐ Toes in
  - ☐ Toes out
  - ☐ Flat/heavy footed
  - ☐ Clumsy/uncoordinated
- ☐ Balance
- ☐ Coordination
- ☐ Pain
- ☐ Orthopedic concerns
  - ☐ Scoliosis
  - ☐ Fractures
  - ☐ Sprains/strains
- ☐ Gross motor development (ex. ball skills, stair climbing, jumping, etc.)
- ☐ Other:_____

_____

Date symptoms started:_____

If unsure of exact date estimation of time frame:

- ☐ Acute (less than one month)
- ☐ Sub-acute (one to three months)
- ☐ Chronic (more than three months)

Equipment used:

- ☐ Wheelchair
- ☐ Braces (ex. AFO, SMO, etc.)
- ☐ Walker/gait trainer
- ☐ Crutches
- ☐ Communication device
- ☐ Eyeglasses
- ☐ Hearing aids
- ☐ Other:_____

Goals for physical therapy intervention:_____

_____

_____

_____

Music Therapy

Has your child ever had any musical training? _____

Music groups? ☐ Kindermusic ☐ Choir ☐ Music class ☐ School music

What types of music does your child enjoy? Check all that apply

☐ Rock	☐ Classical	☐ Pop	☐ Hip hop
☐ Soundtracks	☐ Bluegrass	☐ New Age	☐ Jazz
☐ Country	☐ Top 40	☐ Children's	☐ R&B

Favorite songs: _____

_____

Music dislikes: _____

_____

How does your child respond to music? (e.g., dance, sing, rock) _____

_____

Is your child sensitive to sounds? (e.g., trains, alarms, humming sounds) _____

_____

Do you sing to your child? ☐ Yes ☐ No If yes, what and when? _____

_____

Do you have any musical instruments at home? ☐ Yes ☐ No If yes, which ones? _____

_____

Does anyone in the home play an instrument? ☐ Yes ☐ No If yes, what? _____

_____

Please list three strengths of your child:

1. _____
2. _____
3. _____

Goals you are hoping to accomplish through music therapy (check all that apply):

☐ Attention span	☐ Eye-hand coordination
☐ Increase focusing	☐ Increase speech
☐ Increase fine motor skills	☐ Increase gross motor skills
☐ Cognitive skills	☐ Relaxation skills
☐ Behavioral skills	☐ Following directions
☐ Eye contact	☐ Sequencing skills
☐ Turn taking	☐ Social skills
☐ Expressions of feeling	☐ Other: _____

Additional comments: _____

PROFESSIONAL THERAPY SERVICES, INC.

1015 Oakhurst Drive
Charleston, WV 25314
TELEPHONE: (304) 345-8101 www.wvpts.com FAX: (304) 345-7386

"PLAYING TO SUCCEED"

CLINIC POLICY AGREEMENT FORM

Thank you for choosing Professional Therapy Services, Inc. to support your child's therapy needs. Our goal is to provide effective, evidence-based treatment to help your child achieve their speech, occupational, physical, and/or music therapy goals.

Please review our policies on financial/referrals, attendance, weather, and parking. Initial each section and sign at the bottom to confirm you've read and understood the information. A copy will be provided for your records.

If you have any questions, feel free to contact our office at (304) 345-8101.

Financial Policy

- Any and all co-payments, deductibles, and coinsurance amounts are due and payable at the time of service. PTS can automatically run credit/debit card for each visit to ensure timely payment.
  - ☐ **YES- I would like my card to be charged each session.** (please check with office to make sure correct card information is on file)
  - ☐ **NO- I will stop by the office each session to pay.**
- Any services which are deemed "non-covered" or "not medically necessary" by your insurance company or other payor source are your responsibility.
- It is your responsibility to inform PTS of any changes in insurance coverage (ex. insurance termed, change of insurance providers, etc.). If PTS is not informed in a timely manner on insurance changes, then charge for services during the delinquent period will be your responsibility since retroactive billing is often not an option, particularly when prior authorization for services is requested and must be paid.
- Any **no show** to appointment(s) is subject to a **$20 charge** for each therapy session missed.
- Clients with account balances **over $200** will be placed on hold until balance is paid. If balance is not paid (or payment plan in place) within 30 days, client will be taken off schedule.

Initial Here:_____

Referral:

- It is your responsibility to inform PTS of any changes to child's medical team, including pediatrician or referring physician. An updated referral is required every 6-12 months for services to continue.

Initial Here:_____

Attendance Policy

Illness:

- Consistent attendance is one of the best ways to help your child get the most benefit from therapy services. However, illness is unavoidable, and we ask you do not bring your child to therapy if sick.
    - Your child may return 24 hours after a fever or GI symptoms have resolved without medication.
    - If your child has an ongoing illness, surgery, hospitalization, etc. that will require missing multiple services, please contact office. It may be asked to provide documentation from medical doctor.

Cancellations/no shows:

- Your child will be removed from the schedule with any of the following scenarios:
    - **3** no shows (not calling to cancel appointment prior to scheduled time) within a 2-month period.
    - Over a 3-month period attendance is less than **65%.**

*A warning letter may be sent prior to the above scenarios if attendance is not consistent. If there are other factors affecting attendance to therapy sessions, please contact office ASAP.

Initial Here:_____

Weather/School Closings

- When Kanawha County Schools are delayed or closed due to weather, the office will open at 10:00 am. If your therapy appointment is scheduled prior to 10:00 am it will automatically be cancelled. If you would like to reschedule/cancel your appointment due to weather, please contact the office.

Initial Here:_____

Parking

- Parking is limited at PTS so please park carefully to allow as much space for others as possible. Therapists are willing to come out and meet your child in parking lot when parking lot is full. Please call office if you have any questions/concerns at time of appointment.

Initial Here:_____

I have read and agree to the policies stated above:

Signature:_____ Date:_____

Relationship to child:_____

PROFESSIONAL THERAPY SERVICES, INC.

1015 Oakhurst Drive
Charleston, WV 25314

TELEPHONE: (304) 345-8101 www.wvpts.com FAX: (304) 345-7386

"PLAYING TO SUCCEED"

PATIENT CONSENT FORM

As part of your health care, it is necessary to create, maintain and (in certain situations) share medical information concerning your health history and current treatment care services to carry out treatment, payment and health care operations. Our **Notice of Privacy Practices** describes how we may use and disclose your protected health information. You have the right to review our notice before signing this consent.

The terms of our notice may change. We will post a copy of the current notice in our facility. At any time you may request a copy of our notice in effect.

You have the right to request that we restrict how protected health information about you is used or disclosed for health care treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by those restrictions to which we agree.

By signing this form, you consent to our use and disclosure of protected health information about you for health care treatment, payment, and health care operations and you acknowledge that you have received a paper copy of our **Notice of Privacy Practices**. You have the right to revoke this consent, in writing, except where we have already used or disclosed your information in reliance on your prior consent.

_____ _____

Patient/Personal Representative Date

_____ _____

Patient Name Date of Birth

PROFESSIONAL THERAPY SERVICES, INC.

1015 Oakhurst Drive
Charleston, WV 25314
TELEPHONE: (304) 345-8101 www.wvpts.com FAX: (304) 345-7386

"PLAYING TO SUCCEED"

Effective 4/1/2025

Medicaid patients **MUST PAY** for:

- Services NOT covered by Medicaid
- After Medicaid benefit is exhausted
- Not medically necessary
- Not approved by the Managed Care provider (except for medical emergency)
- Convenience items not related to the medical care
- Services provided when a patient is not eligible
- Services from a provider who tells a patient that he/she will not bill Medicaid before the services are provided
- Services provided when the patient refuses to use other private insurance
- Services provided when the patient does not follow the plan provisions of their primary insurance, which includes but is not limited to utilizing in-network providers and following all pre-certification guidelines
- Any Medicaid co-payments that apply to the services the patient receives

*Medicaid members must not be billed or otherwise held responsible for claims denied for provider error.

It is every client or responsible party's obligation to inform Professional Therapy Services, Inc, of any change of insurer or Agency immediately upon transfer. If PTS is not informed in a timely manner, charges for services during the delinquent period will become your responsibility since retroactive billing is often not an option, particularly when prior authorization for services is required.

By signing this form, I, the undersigned, acknowledge I have both read and understand all the terms and information contained herein. Ample opportunity has been offered to me to ask questions regarding any unclear information contained herein.

Signature of Client or Responsible Party: _____ Date:_____

Office Staff/Witness-_____