Aura's Therapy Center, LLC

3115 Citrus Tower Blvd., Suite D, Clermont, Florida 34711
Phone: (407) 374-8010 Fax: (407) 536-5801
aurastherapy@gmail.com
www.aurastherapy.com

NEW PATIENT INTAKE FORM

Speech Therapy & Occupational Therapy

PERSONAL INFORMATION

Child's Name: (Last, First, Middle) **Date:**

Date of Birth: **Age:** **Gender:** ☐ **Female** ☐ **Male**

Address: (Number, Street, City, State, Zip)

Insurance: **Member ID:**

Does the child live with both parents: ☐ **Yes** ☐ **No**

Mother's Name:	**Cell Phone:**
Mother's Occupation:	**Work Phone:**
Email:	**Daytime Phone:**
Father's Name:	**Cell Phone:**
Father's Occupation:	**Work Phone:**

Referring Office:	**Doctor's Name:**	**Doctor's Phone:**

Who does the child resides with? (check one)

❑ Birth Parents ❑ Foster Parents ❑ One Parent ❑ Adoptive Parents

❑ Parent and Stepparent ❑ Other: _____

Other Children in the Family:

Name	Age	Grade	Speech/Occupational Problems

With whom does the child spend most of his or her time?

What is the child's primary language?

What language are spoken at home other than English?

Which language does your child prefer to speak at home?

Do you feel your child has a ___ Speech Problems ___ Occupational Problem?

Please describe your concern:

Has she/he ever had a speech evaluation or occupational evaluation? ☐ **Yes** ☐ **No**	
If yes, where and when?	**When was the child seen?**
What were the specialist's conclusions or suggestions?	
Is your child aware of, or frustrated by, any speech/language or occupational difficulties?	
What do you see as your child's most difficult problem in the home or in school?	
How does the child usually communicate? (check one) ❑ Gestures ❑ Sign Language ❑ Sounds (vowels, grunting) ❑ Single Words ❑ Shorts Phrases ❑ Others: _____	
Is there any history of any family member with speech and language deficit? ☐ **Yes** ☐ **No** **If yes, please include which immediate family member.**	
Speech Problems:	Hearing Problems:
Seizures/Convulsions:	Autism/Spectrum Disorder:
Others: _____	

BIRTH HISTORY

Mothers' general health during pregnancy (illnesses, accident, medications, etc.)	

Length of Pregnancy	Length of Labor	Birth Weight	General Condition	Type of Delivery

Were there any unusual conditions that may have affect the pregnancy of birth? ☐ **Yes** ☐ **No**	
If yes, please describe:	
How old was the mother when the child was born?	
Did the child go home with her mother from the hospital? ☐ **Yes** ☐ **No**	
If the child stayed at the hospital, please describe why and how long:	
Did child experience any early feeding/swallowing problems (weak, suck, turning ''blue'' while attempting to nurse, projectile vomiting, choking, lack of appetite, early fatigue, milk coming out nose while nursing, etc.)?	

MEDICAL HISTORY

Has your child has/had any history of the following? Please explain:

❑ There is no history of the following:

❑ Ear Infections/Ear Tubes ❑ High Fever ❑ Frequent Colds/Sinus Infection ❑ Breathing Difficulties

❑ Head Injury ❑ Tonsils/Adenoids Removed ❑ Sleeping Difficulties ❑ Allergies ❑ Vision Problems

❑ Chicken Pox Explain: _____

_____

How often?

Describe any major accidents, hospitalizations or any serious injury/surgery:

Does child have a medical diagnosis? (Autism, Dyslexia, Apraxia, Down Syndrome, Developmental Delay, etc.)

Is your child currently or recently under a physician regularly? ☐ **Yes** ☐ **No**
If yes, why?

Is the child taking any medications? ☐ **Yes** ☐ **No**
If yes, explain.

DEVELOPMENTAL HISTORY

Please tell the approximate **age** your child achieved the following developmental milestone:

Sat alone	Crawled	Stood up	Walked	Babbled	Said first words
Respond to his/her name	First ate solid food	Put two words together	Spoken in short sentences	Grasped crayon/pencil	Toilet trained

Does your child:

❑ Choke on food or liquid? ❑ Currently put toys/objects in his/her mouth?

❑ Brush his/her teeth and/or allow brushing?

Current Speech – Language
Does your child:

❑ Repeat sounds, words or phrases over and over?

❑ Understand what you are saying?

❑ Retrieve/point to common objects upon request (ball, shoe, cup, etc.)?

❑ Follow simple directions (“Shut the door” or “Get your shoes”)?

❑ Respond correctly to Yes/No questions?

❑ Respond correctly to Who/What/Where/Why questions?

Please describe your child's gross motor skills (coordinated, clumsy, falls a lot, slow, etc.) while running, climbing riding bikes, roller skating, etc.

Please describe your child's fine motor skills while attempting to color, write, draw, and cut with scissors, feed him/herself with utensils, etc.

Has your child hearing been tested previously? ☐ **Yes** ☐ **No**

If yes, when, where and what were the results?

Indicate with a checkmark any items that are difficult for your child:

❑ Eating variety of foods ❑ Understanding what he/she hears ❑ Following directions or routine

❑ Stating sounds of letter ❑ Answering questions ❑ Pronouncing words correctly

❑ Eye-hand coordinator ❑ Understanding spatial concepts ❑ Touching different Textures

❑ Self-calming ❑ Receiving/giving hugs ❑ Keeping shoes on

❑ Writing his/her name ❑ Blowing bubbles ❑ Using a straw

❑ Speaking organized and grammatically

BEHAVIORAL HISTORY

Please check all that describe for your child:

❑ Friendly ❑ Impulsive/Impatient ❑ Separation difficulties ❑ Easy going ❑ Difficulty Sleeping

❑ Eats well ❑ Poor eye contact ❑ Hyperactive ❑ Cooperative ❑ Attentive

❑ Defiant ❑ Cries easily ❑ Aggressive destructive ❑ Snores ❑ Talkative

❑ Bite nails ❑ Stubborn still ❑ Grind's teeth ❑ Quiet ❑ Bad-tempered

❑ Shy ❑ Poor memory ❑ Has nightmares ❑ Sleeps well ❑ Wet's bed

❑ Restless ❑ Easy frustrated ❑ Mouth breather ❑ Often sensitive to sound

❑ Pacifier/suck thumb ❑ Willing to try activities ❑ Play well with other children

❑ Does not like to read ❑ Has temper tantrums ❑ Will not eat certain textures

❑ Will not touch certain textures ❑ Overly sensitive emotionally ❑ Does not like to be touch

❑ Distractible/short attention span ❑ Cannot easily shift from one activity to another

❑ Plays alone for reasonable amount of time

EDUCATIONAL HISTORY		
School Attending	**Grade**	**Teacher**
How is the child doing academically (or pre-academically)?		
Does the child receive special services? ☐ **Yes** ☐ **No** **If yes, describe:**		
How does the child interactive with others (shy, aggressive, uncooperative, etc.)?		
Please provide any additional information that might be helpful in the evaluation or remediation of the child needs:		
Person completing form:	**Relationship to child:**	
Signature:	**Date:**	

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THERAPY CONSENT

Child's Name	Parent/Guardian's Name

CONSENT FOR TREATMENT OF A MINOR

❑ As parent and/or legal guardian, I authorize **AURA'S THERAPY CENTER, LLC** to treat and/or evaluate my child.

Parent/Guardian's Name	Date

CONSENT FOR BILLING

❑ I understand that I am responsible for all charges incurred for therapy services provided for my child, regardless of insurance coverage. I understand that **AURA'S THERAPY CENTER, LLC** bill my personal insurance carrier as a courtesy and that I am responsible for the bill. I am responsible for keeping **AURA'S THERAPY CENTER, LLC** up to date on any changes to my plan or policy.

❑ I understand that if my insurance carrier does not remit payment **AURA'S THERAPY CENTER, LLC** within 60 days, the balance owed will be due in full from me.

Parent/Guardian's Name	Date

CONSENT FOR RELEASE OF INFORMATION

❑ I, _____, give permission for Pediatric.

❑ **AURA'S THERAPY CENTER, LLC** to exchange information on child _____. By signing this form, I understand that **AURA'S THERAPY CENTER, LLC** may contact the persons or agencies (i.e. physician, other therapy agencies, school programs, etc.) listed below to obtain more information on my child, such as reports or evaluations. In addition, **AURA'S THERAPY CENTER,**

LLC may contact and send copies of goals, reports and other pertinent information to the agencies/individuals listed below.

Agency/Name	Address	Telephone	Date
Agency/Name	**Address**	**Telephone**	**Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OR PRIVACY PRACTICES

❑ I, acknowledge that I have received the Notice of Privacy Practices (Notice). The Notice describes, in accordance with the HIPPA Privacy Regulations, how **AURA'S THERAPY CENTER, LLC** may use and disclose my child's protected health information to carry out treatment, payment or health care operations and for the other specific purposes that are permitted or required by law. The Notice also describes my rights and **AURA'S THERAPY CENTER, LLC** duties with respect to protected health information about my child.

CONSENT FOR PARTICIPATION WITH THERAPEUTIC EQUIPMENT

❑ Intervention programs at **AURA'S THERAPY CENTER, LLC** usually involve the use of specialized equipment such as suspended equipment and various swings, bolsters, inflated therapy balls, climbing structures, hanging bars, tactile media (such as soap foam, Play-Doh and lotion), and a variety of other activities that involve fine, gross and oral motor coordination. Therapy activities often involve encouraging the child to try new things in ways that are changeling in order to foster increased skills and abilities. While **AURA'S THERAPY CENTER, LLC** staff makes great efforts to ensure each child's safety, the nature of the therapeutic intervention includes the risk of falling, bumping into other people/equipment. I am aware of the internet risk of this type of activity, and I give permission for my child to participate in therapy as described.

Parent/Guardian's Name	Date

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TELETHERAPY CONSENT FORM

Tele-practice (the act of providing Telehealth services) as "the application of telecommunications technology to delivery of professional services at a distance by linking clinician to client, or clinician to clinician for assessment, intervention, and/or consultation". The therapist and the patient would join a computer-based session at the designated therapy time and would work on the same materials as in the office. We term this "teletherapy".

I _____ hereby consent to engage in teletherapy with **Aura's Therapy Center, LLC.** I understand that "teletherapy" includes treatment using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical information, both orally and visually.

- I consent to receiving treatment from **Aura's Therapy Center** via telehealth video sessions that use live, interactive, audiovisual communication technology.
- I understand that my participation in telehealth video sessions is purely voluntary and I may discontinue a telehealth video session at any time. (In addition, I understand that a telehealth video session may not be appropriate in all situations and that, in some instances, my provider may not be able to fully observe or assess my condition.)
- I understand that during a telehealth video session, my provider may determine that it would be more appropriate to continue treatment in person. In such cases, your provider will use reasonable efforts to refer you to in-person providers and other resources that may be available in your local areas. However, Aura's Therapy Center cannot guarantee the availability of resources and access to those resources could involve the need to travel and possible delays in receiving services.
- I understand that telehealth video sessions cannot and will not be recorded.
- I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

- I understand there are risks and benefits involved in receiving treatment via a telehealth video session. The benefits include increases access to, and availability of, health services. The potential risks include but are not limited to:

- The possibility that my telehealth video session could be interrupted by technical issues, such as delayed response time due to connectivity problems.

- Inadvertent disclosure of my health information (such as, for example, in the event of unauthorized access by a third party), even though the technology platform used for the telehealth video sessions is encrypted and data security measures have been put in place to ensure my health information remains confidential.

- I understand that telehealth video sessions are not for emergencies. If I am experiencing and emergency, I will call 911.

- I confirm that I will sign into the session at the assigned date and time found in the invitation at least 15 minutes prior to the beginning on my first telehealth video session and, if I experience technical issues, I will contact my provider by secure message to troubleshoot.

If a technical issue arises during a telehealth video session, contact your provider

Patient Name:	
Parent's Name:	
Parent's Signature:	
Date:	

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HIPPA Release Form

I, _____, parent/guardian of patient _____ give permission to **AURA'S THERAPY CENTER, LLC** and all employees to discuss and/or receive information, including medical records concerning any and aspects of patient's previous healthcare by doctor, physical, occupational or speech therapist, or other medical professional. This release is required to obtain medical information according to the privacy rule detailed in HIPPA (The Health Insurance Portability and Accountability Act of 1996).

Patient Name:	
Date of Birth:	
Patient's Social Security:	
Parent/Guardian's Name:	
Parent/Guardian's Signature:	
Date:	

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Cancellation Policy

Due to the overwhelming need for our services, it is our policy to discharge those who are unable to make the necessary commitment to their child's therapy sessions. The reserved appointment slot is for your child and only your child. A patient will be discharged after the third un-notified absence. If your child is sick, we need a doctor's note to waive the $50 cancelation fee, unless specifically exempted to do so by law. We reserve the right to a $50 charge on any non-valid appointment cancellations to your account. You will be fully responsible for paying the $50 charge for no-show sessions. Cancelation charges must be paid before the next therapy session. Your insurance will not pay for it. If we know you are unable to attend your session in advance, we can make the necessary adjustments to our schedule. Thank you!

Patient Name	**Date**
Parent Name	**Parent Signature**

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AUTHORIZATION AND CONSENT FOR TAKE PHOTOGRAPHS, VIDEOS AND IMAGE PUBLICATIONS

I, _____ as the parent/legal guardian of the child _____ patient of **AURA'S THERAPY CENTER, LLC**

❑ **YES** ❑ **I DO NOT** authorize **AURA'S THERAPY CENTER, LLC,** to make photographs, video recordings in various activities, and therapies performed and the publication of these on blogs and/or Center Websites, understanding that they are accessible to anyone connected to the Internet,

Birthday Celebration ❑ Opt. **In** ❑ Opt. **Out**

Parent/Guardian's Signature	**Date**

RELEASE OF RESPONSABILITY

I, _____, certified that **AURA'S THERAPY CENTER, LLC** guided me on the snacks that my child could participate in as long as I am assured that it does not contain any ingredients to which he may be allergic. Authorizing it is voluntary and I do so assuming all the risks and absolute responsibility.

❑ **I authorize.**

❑ **I do not authorize.**

❑ **Allergies** _____

Therefore, **AURA'S THERAPY CENTER, LLC is release for any responsibility.**

Parent/Guardian's Signature	**Date**

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Days & Hours Available

Child's Name

To schedule therapy services, we need to know what days and hours you have available. Please select day and write the hours available.

- ❑ Monday Hours: _____
- ❑ Tuesday Hours: _____
- ❑ Wednesday Hours: _____
- ❑ Thursday Hours: _____
- ❑ Friday Hours: _____

Parent Name	Date

Office Policies

Your child's appointment is a time that has been *reserved* for your child exclusively with his/her therapist. We understand that your time is very valuable to you, to respect *your* time, therapist's time and that of our other patients. We do understand that we all have busy lives and things can come up at the last minute from time to time, however, below are office policy reminders.

APPOINTMENT CANCELATION/NO-SHOW NOTICE

1. Cancellations and no shows appointments will be subject to a $50 cancelation fee, that *must* be paid before the next therapy session.
2. If your child is sick and cannot make it to his/her appointment, we require a doctor's note. The $50 fee will be waived.
3. If canceling becomes a routine/pattern you will be charged the cancelation fee and your child's *reserved* appointment time slot may be revoked and you will be placed on a on call basis.

COMING LATE FOR CHILD PICK UP

1. Parent/Guardians you are ***NOT*** allowed to leave the office/premises during your child's therapy session. If your child needs to use the restroom (by law we cannot assist your child), needs a diaper change or a building emergency were to occur, your child will need ***you***. It is extremely important that you are here.
2. Parents/Guardians, you cannot come 5-20 minutes after your child's therapy session has ended. ***This will not be allowed***. DCF came to visit, and we were made aware that a child cannot be in our office without a parent/guardian. Parents/guardians **must** be in the building or on the premises. We understand this will be an adjustment for some of you. But we do have to comply with the law.
3. We encourage you to be inside the office 5-10 minutes before the end of your child's therapy session, so your child's therapist can discuss progress with you. If you're not here, the therapist may not be able to discuss your child's progress.

WHEN THERAPISTS HAVE EMERGENCIES

We have an amazing team of therapists that are committed to your child's progress. We understand that things will come up in their lives that will cause them to call out for the day.
When therapists cannot make it to the office, procedure is as follows:

1. If your child has an appointment, and there is an opening with another therapist in the same time slot, our system will automatically move your child over to the available slot. Parent/guardians these changes are necessary for your child. As they grow, they'll have to adjust to changes in their lives. And our mission is to make sure your child gets his/her therapy so they can continue to reach their goals.
2. If you choose to not see another therapist, you will be charged the $50 cancelation fee.

MEDICAID/FLORIDA KID CARE PATIENTS

Medicaid and Florida kid care applications ***must*** be renewed every year. It is your responsibility to do the renewal on time.

1. If you don't renew your Medicaid on time, you must call our office and let us know so we can cancel your child's future appointments.
2. If you don't call us on time and you miss or cancel your child's appointment, you have the option to pay for the therapy session out of pocket or if you choose not to pay for the therapy session, you'll get a $50 cancelation fee that must be paid before his/her therapy sessions.
3. If you don't make your Florida kid care premium on time and your child's health plan goes inactive, you have the option to pay for the therapy session out of pocket until the plan is active again or if you choose otherwise, you'll get a $50 cancelation fee that must be paid before his/her therapy sessions.
4. We cannot hold your child's ***reserved*** time slot for more than two weeks. No Exceptions. If it takes longer than two weeks your child will lose his/her reserved time slot. Once the plan is active again, we'll give you the new available time slots available.
5. If your child has an after-school time slot you will not want to lose that time slot as we have patients on a waiting list for after school.

VACATIONS

Parents/guardians, we all need some rest and disconnect time. We encourage rest time in small doses. Your child still needs to continue with his/her therapies and if your child goes too long without continual therapies, they lose progress. At times making your child get frustrated.

1. When planning a vacation please let us know at least ***two weeks*** before. Do not call us the ***week of*** to cancel your child's appointments. In waiting until the last minute, you'll be responsible to pay the cancelation fee of $50 which must be paid before your child's next therapy session.
2. We can hold your child's reversed time slot for only ***two*** weeks.
3. For families that take both months of summer vacation. Your child will lose his/her reserved time slot. You'll have to call us the week before your child will be ready to continue his/her therapies. At that time, we will let you know what we have for availability. And do know your child will lose some of the progress he/she has made.

In Aura's Therapy Center, good treatment and personalized attention to your children is our work policy. We appreciate your cooperation in this matter. We love each one of our patients. We strive to make them feel comfortable and part of a family. Our greatest joy is to see your child meet their goals.

Parent Signature: _____ **Date:** _____

Office Rep.: _____ **Date:** _____