5979 NW 151st Street • Suite 208
Miami Lakes, FL 33014
Ph: (305) 362-3300 / Fax: (305) 362-0202
info@mytamail.com

CHILD CASE HISTORY

General Information

Child's Name: _____ Mother's Name: _____

Date of Birth: _____ Father's Name: _____

Address: _____ Does the child live with both parents: _____

City: _____ ST: _____ Zip: _____ Referred by: _____

Home Phone: _____ Pediatrician: _____

Cell Phone: _____ Phone: _____

Brothers and Sisters (include names and ages):

Name	Age

What languages does the child speak? What is the child's dominant language?

What languages are spoken at home? What is the dominant language spoken?

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

Describe the child's speech-Language problem?

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How does the child usually communicate (gesture, single words, short phrases, sentences)?

When was the problem first noticed? By whom?

Has the problem changed since it was first noticed?

Has any other specialist seen the child? If yes, indicate the type of specialist and when the child was seen.

Prenatal and Birth History

Mother's general health during pregnancy (illness, accidents, medication, etc.)

Medical History

Has the child had any surgeries? If yes, what type and when?

Is the child taking any medications? If yes, please identify.

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Developmental History

Provide the approximate age at which the child began to do the following activities:

Crawl_____
Walk _____
Sit _____
Stand _____
Use single words (i.e. no, mom, doggie)_____
Combine words (i.e. me go, daddy shoe) _____
Name Simple Objects (i.e. dog, car, tree) _____
Use simple questions (i.e. Where's doggie?) _____

Feed Self_____
Dress Self _____
Use toilet _____

Does the child have difficulty walking, running, or participating in other activities that require small or large muscle coordination?

Are there or have there ever been any feeding problems (i.e. problems with sucking, swallowing, drooling, chewing)? If yes, please describe.

Describe the child's response to sound (i.e. responds to all sounds, responds to loud sounds only, inconsistently responds to sounds).

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Educational History

School: _____ Grade: _____

How is the child doing academically (or pre-academically)?

Does the child receive special services? If yes, please describe.

How does the child interact with others (i.e. shy, aggressive, uncooperatively)?

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ Social Security: _____

SECTION B: To the patient – Please read the following statements carefully

Purpose of consent. By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Address: _____

Telephone: _____ Fax: _____

Right to Revoke. You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____Date: _____

If other than patient, relationship to patient _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT ****

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: _____

Signature: _____

If other than patient, relationship: _____

Date: _____

OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other _____

Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION ASSIGNMENT OF INSURANCE BENEFITS AND TREATMENT

I authorize any holder of medical or other information about me to release to Therapy Alliance, Inc. and any information needed for therapy or any related insurance claim. I request that payment of authorized benefits be made to Therapy Alliance, Inc. furnishing the services. I understand that I am responsible A) for any amounts applied to the deductible, as well as the percentage of co-insurance and any non-covered services under the Medicaid program and B) for charges not paid by my insurance.

I hereby authorize relevant therapist(s) from Therapy Alliance, Inc to provide therapy care for me/my child. I further understand that this therapist is licensed in the state of Florida under his/her discipline and is employed by Therapy Alliance, Inc.

THERAPY ALLIANCE, INC
CANCELLATION POLICY

Therapy Alliance, Inc requires a 24 hours cancellation notice or charges will be billed for the scheduled therapy. It is not our intent to penalize anybody for legitimate emergencies or illness which may not permit you to notify us 24 hours prior to your appointment and each instance will be individually reviewed.

Date _____ _____
Patient's Name

Witness _____ _____
Patient/Parent Signature

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THERAPY ALLIANCE REHABILITATION SERVICES ATTENDANCE AGREEMENT

WELCOME TO THERAPHY ALLIANCE REHABILITATION SERVICES. IN ORDER FOR YOUR CHILD TO RECEIVE HIS/HER TREATMENT PLAN AND CONTROL THERAPY COSTS, CONSISTENT ATTENDANCE IS REQUIRED. IN ADDITION, SINCE THERE ARE MANY CHILDREN WAITING TO RECEIVE TREATMENT THROUGH OUR DEPARTMENT, IT IS NECESSARY THAT WE MUTUALLY AGREE AND ADHERE TO THE FOLLOWING ATTENDANCE POLICIES:

1) **Availability Therapy Session Policy**
   a) You will be expected to arrive on time to our child's appointment start time and at least 10-15 minutes before the appointment end time.
   b) You are required to be readily available at ALL TIMEs while your child is receiving therapy. If you remain in our waiting area or outside the building is up to your discretion, but you will be expected to be ready in a matter of minutes if a particular situation calls for it.

2) **Cancellation of an Appointment Policy**
   In order to be respectful of the medical needs of other patients and the time utilization of our therapists, please be courteous and give us a call promptly if you are unable to show up for an appointment. We will do our best to reallocate this time to someone who is in need of treatment.
   At the same time, we will do our best to try to reschedule the appointment at a more convenient time.
   Please note that:
   - We can only re-schedule appointments to open time slots at the time you call us, so availability may be an issue.
   - If your child receives more than one therapy, finding consecutives open time-slots it is not guaranteed at all.

3) **How to Cancel an Appointment.**
   a) To cancel appointment/s, please call at (305)362-3300 24 hours in advance. If you do not reach the receptionist you may leave a detailed message on the voice mail clearly stating your name; patient's name; scheduled therapy/therapies type; date and time of the appointment/s you are trying to cancel; and best phone number to reach you.

4) This procedure is not limited to therapy services provided at our clinic, but it also includes appointments scheduled at home, school, daycare center etc….

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5) **How to Re-schedule an Appointment.**
   a) If you would like to reschedule your appointment/s, please call us at least 24 hours in advance at (305)362-3300 and let us know. If you do not reach the receptionist you may leave a detailed message on the voice mail clearly stating your name; patient's name; scheduled therapy/therapies type; date and time of the appointment/s you are trying to reschedule; and best phone number to reach you. We will return your call and give you the next available option.
   b) This procedure is not limited to therapy services provided at our clinic, but it also includes appointments scheduled at home, school, daycare center etc….

6) **Late Cancelation.**
   a) A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24 hour advance notice.

7) **"No Show" Policy.**
   a) A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show".
   b) In the event your child is receiving therapy at a learning center, school, childcare or home, we need your cooperation in calling us 24 (twenty four) hours in advance if the child will not be present at that location on the scheduled date. Failure to comply will be considered a **"No Show"**.
   c) If your child is receiving the therapy at our clinic, telephone notification is required 24 (twenty four) hours prior to the appointment. Failure to comply will be also considered a **"No Show"**.

8) **Late Arrival Policy**
   a) Patients who arrive late are not guaranteed a complete treatment session on that day.
   b) Session end time will not be moved to make up for late arrival, unless treating therapist schedule is available, but this occurrence is not implied or guaranteed in any way.

9) **"Late Pick-Up" Policy**
   a) A Parent, guardian, or legally designated person must be at least readily available throughout the child's treatment and physically present 10-15 minutes before session end time. Failure to comply with this policy will be recorded in the patient's chart as a "Late Pick-up 10", "Late Pick-up 20", "Late Pick-up 30" for each incremental (complete or partial) period of 10 minutes. Under no circumstances are children to be left alone/unattended in the waiting room or the building; before or after their therapy session.
   b) Patient safety, care and supervision before allowed into the therapy area and after session end time, will be considered EXCLUSIVELY a parent, guardian, or legally designated person RESPONSABILITY.
   c) Therapy Alliance Inc. including, but not limited to; their therapists, vendors, employees, managers, owners, associates, shareholders, insurance providers, etc…assume no legal-responsibility, accountability or liability for patient's care, safety or supervision until they are allowed into the therapy area or after the scheduled therapy end time.

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10) PLEASE KEEP IN MIND:

1. Therapy Alliance Inc. reserves its right to refuse services.
2. It is not our intent to penalize anybody for legitimate emergencies or illness which may not permit you to notify us 24 hours prior to your appointment and each instance will be individually reviewed.
3. The first time there is a "no-show", late cancellation, or cancellation without a reasonable excuse there will be no charge to the patient.
4. The 2nd "no-show", late cancellation, or cancellation without a reasonable excuse will result in a **patient's responsibility fee** of $25.00 (not billed to or payable by the patient's insurance carrier) and due before the next scheduled appointment.*
5. The 3rd "no-show", late cancellation, or cancellation without a reasonable excuse will result in a **patient's responsibility fee** of $50.00 (not billed to or payable by the patient's insurance carrier), due before the next scheduled appointment and may result in a discharge from the practice.*
6. Two consecutive **"no shows"** will result in child's frequency of treatment be reduced, removed from the assigned schedule time slot or discharge from the practice due to noncompliance.
7. Each incremental (complete or partial) period of 10 minutes of "Late Pick-Up" will result in a **patient's responsibility fee** of $20.00 (not billed to or payable by the patient's insurance carrier) and due before the next scheduled appointment.*
8. If your child is still here 30 minutes after the therapy end time, and we have not been able to reach anyone at the emergency numbers, the Local Sheriff's Office will be notified. The pick-up time is important to assure proper patient care and safety and MUST be strictly followed.

We thank you in advance for your understanding and cooperation.

I, _____ have had receive and consider the contents of this Attendance Agreement. I understand that, by signing this, I'm acknowledging and committing to follow the policies and procedures stated above.
I also understand that failure to abide by these policies will result in:

- Charges to my patients' account. (where applicable)*
- That will not be billed to, or payable by, my insurance carrier.
- Services will be suspended until patient account is balanced.
- May lead to reduction of therapy or to refuse service if necessary.

_____ _____
Signature of parent/legal guardian Date

_____ (_____)_____-_____
Parent/legal guardian full name Emergency contact phone #

*- Conditions and restrictions may apply depending on insurance carriers.

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Patient Name: _____ DOB: _____

Statement of Patient Financial Responsibility

Therapy Alliance Inc. appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by **your** contract with **your** insurance carrier. We will submit insurance claims for our patients. However, the agreement of the insurance carrier to pay for medical care is a contract between **you** and the **carrier**. You should direct any questions and/or complaints regarding coverage to your insurance carrier. We expect any deductible and co-payment/co-insurance payments at time of service.

Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

We do not bill third parties. It is the responsibility of the patient to satisfy any outstanding balances here. We will provide statements as proof of payment for patients to pursue reimbursement from the third party payer.

All account balances are due prior to your next appointment. **Any outstanding balance over 60 days will be turned over to our collection agency along with a $25.00 collection service fee. You will also be held liable for all reasonable cost of collections and attorney fees.**

Government Assistance programs

Please be aware that some Government Assistance programs (like Medicaid/Medicare) may have exceptions and limitations in regard to patient financial responsibility. Therapy Alliance Inc. strives to abide by these regulations.

However, said conditions may or may not apply to your particular situation, and your health insurance circumstances may change in the future. It is the patient's responsibility to understand his/her medical benefits/responsibilities.

I have read the above policy regarding my financial responsibility to Therapy Alliance Inc., for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Therapy Alliance Inc., the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient/ Parent Signature _____Date _____

Print Name: _____

Cancellation / No Show Policy

Please refer to the "Attendance Agreement" included on this package.

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ Date _____