New Patient Form

**Today’s Date:**

**Child’s first and last name:**

**Preferred Nickname (if applicable):**

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

**Address:**

**City/State/Zip:**

**School: Grade:**

**Parent/Guardian Name:**

**Occupation:**

**Phone:(Home)**

**(Work)**

**(Cell)**

**Email:**

**Parent/Guardian Name:**

**Occupation:**

**Phone:(Home)**

**(Work)**

**(Cell)**

**Email:**

**EMERGENCY NOTIFICATION: If you will be leaving your child during the session, please ensure your therapist has a way to reach you in the event of an unlikely emergency (i.e. cell phone and/or destination).**

**Name of person(s) who may be accompanying your child to therapy if not a parent:**

**Relationship**

**Pediatrician Name:**

**Phone:**

**Who referred you to us?**

**Sibling names and ages**

**Describe what you hope your child will accomplish in a therapy program/ Reason for Referral:**

**Has your child ever or currently receive(d) any of the following services? (School and/or privately)**

**Service Facility/ Dates of Service**

**Speech Therapy: Y N**

**Occupational Therapy: Y N**

**Physical Therapy: Y N**

**Reading/Learning remediation: Y N**

**Other: Y N**

**(Please provide written reports from these facilities if they are available.)**

**How does your child get along with his/her peers?**

**siblings?**

**adults?**

**What kinds of activities does your child enjoy?**

**Please add any comments or descriptions which will help us to better understand your child and your concerns for your child.**

Medical History

**Please list any diagnoses your child has. (including any learning/developmental diagnosis)**

**Does your child have any allergies? If so, list any medications including epi pen and inhaler.**

**Has your child ever had a seizure? If so, when was the most recent occurrence? Do they take medication to control the seizures?**

**Does your child have any medical precautions?**

**Have there been any hospitalizations? If yes, how recent and for what reason?**

**Has your child had any surgeries? If yes, how recent?**

**Does your child require glasses, hearing aid, special shoe inserts, etc.?**

**Was your child delivered at term? Yes No**

**Type of Delivery: Vaginal C-Section**

**Complications with pregnancy and/or delivery: Yes No**

**If yes, please explain:**

***Immunization Policy***

**The Therapy Gym wants to ensure a safe and healthy environment for all children and staff. Please verify if your child’s immunizations are up to date.**

**Yes**

**No**

**Parent’s Signature: Date:**

***Developmental Checklist***

**Please check off all motor skills that you have observed your child do. Please state the approximate age the skill was achieved (all normative ages according to the HELP Checklist):**

**Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Milestone:** | **Did it occur BY this age:** | **If No, approximately what age did you observe:** |
| **Rolling over (belly to back)** | **2-5 months Y N** |  |
| **Independent sitting** | **5-8 months Y N** |  |
| **Crawling** | **9-11 months Y N** | **Did not crawl at all Y N** |
| **Uses both hands at midline** | **16-18 months Y N** |  |
| **Independent standing** | **11-13 months Y N** |  |
| **Walking** | **12-15 months Y N** | **Walks on toes, or did when younger: Y N** |
| **Running (fast)** | **18-24 months Y N** |  |
| **Ascending stairs (2 feet on step with handrail)** | **15-18 months Y N** |  |
| **Descending stairs (2 feet on step with handrail)** | **15-18 months Y N** |  |
| **Jumping with feet together (in place)** | **22-30 months Y N** |  |
| **Jumping off surfaces (ie. curbs, step)** | **24-26 months Y N** |  |
| **Hopping** | **30-36 months Y N** |  |
| **Catches eight-inch ball** | **35 months Y N** |  |
| **Tricycle riding** | **32-36 months Y N** |  |

Sensory Processing/ Observational Checklist

**Does your child have any difficulty with any of the following (“Yes” response indicates difficulty with behavior described)**

**Sensory**

Tolerating loud noises: Y N

Tolerating bright light: Y N

Tolerating clothing/tags: Y N

**Coordination, Vestibular, and Proprioception**

Appears stiff and/or awkward when moving: Y N

Clumsy- bumps into objects or people, falls or stumbles frequently: Y N

Poor posture- cannot sustain upright standing/sitting postures: Y N

Initiating movements: Y N

Using both sides of the body i.e.: right and left: Y N

Awkward gait, unsteady walking, drags feet: Y N

Imitating movements: Y N

Balance activities: Y N

Negotiating obstacles while walking: Y N

Craves bouncing, swinging, rocking more than most kids: Y N

Doing motor activities that he/she previously was able to do: Y N

Holding body in position for periods of time (such as a Yoga pose): Y N

Tolerates feet being off the ground: Y N

Car Sickness: Y N

**Everyday Activities**

Baths (including hair washing): Y N

Getting to sleep/staying asleep: Y N

New foods/certain types of foods: Y N

**Engaging with Others**

Playing with peers: Y N

Age-appropriate strength: Y N

Tolerating activity without fatigue as compared to peers: Y N

Hopping, skipping, running, etc. as compared to peers: Y N

Separation from parents/siblings: Y N

Tolerating activities without tantrums: Y N

Dealing with crowds: Y N

**Activities**

Engaging in activity for extended time: Y N

Playing without getting frustrated: Y N

Following several instructions: Y N

Trying or learning new games or activities: ` Y N

New experiences: Y N

Transitions (switching) between activities: Y N

Participating in organized group activities: Y N

Playing on playground equipment or trying new equipment: Y N

Playing catch: Y N

Completing age-appropriate puzzles: Y N

Describe your child’s playtime activities, including toys he/she prefers or avoids:

**Speech-Language Diagnostic Questionnaire**

**(If applicable and/or interested in Speech Therapy)**

**What is most concerning you regarding your child’s communication or feeding skills?**

**Medical and Health History**

**1. Currently or in the past, has your child had ear infections?**

**2. Has your child’s hearing ever been tested? Y N**

**If yes, list the facility where testing was completed.**

**3. Is there a family history of any speech, language, feeding, or hearing problems? Y N Please describe.**

**Developmental milestones**

**1. Currently or in the past, does/did your child have any difficulty with the following feeding milestones?**

**\*Bottle/Breastfeeding Y N**

**\*Transitioning from bottle/breast to cup drinking Y N**

**\*Transitioning from softer foods to crunchy/chewy solids Y N**

**\*Managing foods of multi-textures (ex. vegetable soup) Y N**

**\*Chewing and swallowing skills Y N**

**If yes for any of the above, please describe difficulties.**

**2. Does your child have any food or other allergies? Y N**

**If yes, please list them.**

**3. To the best of your knowledge, at what ages were the following speech and language milestones achieved (if not yet achieved leave blank)?**

**\*Babbling**

**\*First Words**

**\*Combining 2-3 words into short phrases**

**\*Speaking in full sentences**

**\*Word comprehension**

**4. Is your child frustrated or aware that he/she is having difficulty with his/her communication or feeding skills? Y N If yes, please describe.**

**PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM**

* I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.
* I agree that telephone messages regarding my appointments, prescription renewals, and all other Protected health Information\* (PHI), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

Home

Office / Other

Cell / Other

* I agree that my PHI may be shared with my spouse.
* I agree that my PHI may be shared with my other medical providers.
* I agree that my PHI may be shared with the following other people:

I understand that I can change any of the foregoing agreements, at any time, by giving written notice to *The Therapy Gym* to the attention of the HIPAA Compliance Officer.

* I agree that *The Therapy Gym* may contact me at any email addresses provided to you by me regarding both PHI and non-PHI.

\*as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time (HIPAA)

Patient name (Please print clearly):

Signature of Patient: Date:

**HIPAA Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and disclosures and Protected Health Information Your PHI may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment, for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the medical practice, and any other use not prohibited by law.

Treatment: We will use and disclose your PHI to provide, coordinate, and/or manage your health care and related services. This might include, for example, providing information to the physician who may have referred you to our practice, or to another medical professional to whom we have referred you.

Payment: Your PHI will be used as needed, to obtain payment for your health care services. For example, in order to obtain approval for a certain amount of treatments from your insurance company, they may require certain relevant PHI be disclosed.

Healthcare Operations: We may use or disclose, as needed, you PHI in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of student therapists, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to student therapists that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law enforcement: Coroners, Funeral Directors, and Organ donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates : Required uses and Disclosures: under the law, we must make disclosure to you and when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Your Rights The following is a statement of your rights with the respect to your protected health information.

You have the right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. There may be charges for copying and for postage if you want the copies mailed to you.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request.

Questions and Complaints If you have any questions about this notice, please ask us.

If you think that we may have violated your privacy rights, you may speak to us and submit a written complaint. You may submit a written complaint to the US Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

INSURANCE COVERAGE

**We are an out-of-network provider. This means that for those with out-of-network insurance coverage, you may be eligible for reimbursement from your insurance company.**

**We bill your insurance company directly for you. We will check your insurance benefits and will submit claims directly to your insurance carrier on your behalf.**

**Insurance reimbursement varies depending on your plan. For example, your out-of-network coverage may be 80/20 after meeting a deductible. This means that if you have a $500 deductible, after you pay the $500, your insurance will cover 80% of the reasonable and customary rate, and you will be responsible to pay the other 20% plus any remaining balance.**

**Depending on your benefits, this can be advantageous to you because you may actually pay less for services than if you were going to an in-network provider. The 20% that you would be responsible for may be less than your in-network co-payment.**

Insurance Information

**Important message: Please read if you have any of the following insurance plans:**

Horizon Blue Cross Blue Shield Insurance

Horizon out of state plans

Empire Blue Cross and Blue Shield

Anthem Blue Cross and Blue Shield

The insurance carriers listed above will pay you, the member, for all services provided out of network. It is your responsibility to either turn those checks over to The Therapy Gym or to submit the money paid via Zelle or Venmo to The Therapy Gym. If a payment is received by you from insurance and you do not turn it over to The Therapy Gym within 30 days of receipt, we will charge your card on file in the amount paid (due to us) plus a 3.5% credit card fee after 30 days.

Zelle: ellie@thetherapygym.com

Venmo: @Elisheva-Fuchs

Thank you for your cooperation in this matter

Signature Date:

# POLICIES

**- SAFETY -**

NO ONE may enter the gym or treatment areas unless accompanied by a therapist or staff member.

This is both for a common courtesy to prevent the interruption of an ongoing treatment session and for the general safety. Our equipment can be dangerous to those who use it or others in the area of equipment use. Because of this, we cannot permit siblings and/or parents to walk through our facility or to use equipment during a child’s treatment time.

Our waiting room should be able to provide a sufficient area for family/friends to wait.

If a parent is participating in a treatment session, other members of the party still must wait in our waiting area.

By following the above safety issues, our therapists and staff can better focus our attention on the treatment of your child and not be distracted by possible liableness issues.

**- FOOD/DRINK -**

We ask that any food/drink brought by clients be kept in the waiting area ONLY. We kindly ask that you take any food with you and clean up any mess in the waiting area.

**- CONFIDENTIALITY -**

We make every effort to maintain the confidentiality of our patients. However, some of our treatment areas may have more than one therapist or student participating at one time. We do not take any photographs or contact any third parties without express written consent.

If you prefer to have privacy when discussing your child, please let the therapist know.

**- ATTENDANCE and CANCELLATION -**

Absences should be limited to illness of parent/child or other family emergencies. We ask that you notify our office as early as possible if your child is unable to attend a session. If we are notified within 24 hours of the session, it will be considered a last-minute cancellation.

Last minute cancellations/no shows will be charged if this occurs more than 3 times.

We make every effort to keep our therapy sessions consistent, as that improves the efficacy of the treatment.

If absences are a frequent occurrence, it is at your therapist’s discretion to discontinue your child’s therapy slot in order to make it available to a client who is more reliable.

**- FINANCIAL POLICIES -**

Payment is due at the time of services. We accept cash, check, credit cards (Visa/Mastercard/Discover) and HSA cards. We require a credit card to be kept on file. The card will be charged at time of visit & will also be charged if a visit is not canceled & the patient does not show up or does not give 24 hours’ notice of cancellation.

In a situation where the child’s parents are separated/divorced, it is our policy that the parent who arranged the sessions is the responsible party. We require written authorization from another party should they be intending to pay for therapies. We will not bill another party without this written consent.

**-PATIENT RECEIPT OF CHECKS –**

In the event that I receive direct payment of any amount due for services rendered, I agree that I will hold such payment in trust for the therapists and I also agree to send such payment to the therapists one week after receipt of the same. I also agree to pay attorney’s fees equal to 33 1/3% of the outstanding balance, plus court costs, in the event the account is turned over to an attorney for collection.

**- INSURANCE -**

We do not participate in any provider networks, that is, we are an out-of-network provider.

We provide a detailed billing receipt (a superbill) upon payment. This can be submitted to your insurance company as a claim if you have out-of-network coverage. We do provide the option to directly bill your insurance company and require that a form of payment must be kept on file such as a credit card so that the balance can be collected from the patient.

We can provide any necessary documentation to the insurance company in order to assist with your reimbursement. We are not responsible for any denials made by the insurance company for any reason including exceeding visit limit, lack of medical necessity, or any other reason given by insurance. It is the members responsibility to pay The Therapy Gym for any service provided. Please note any third party rate reductions made by the insurance company will be the reason for The Therapy Gym to no longer bill the insurance on behalf of the patient and the patient IS responsible for payment in full.

Please sign below indicating that you have read and understand these policies.

Name (Print)

Signature Date

***Credit Card Authorization***

Credit card charges for services will be processed by **The Therapy Gym**. If you use a credit

card to pay for your child's services, please provide us with **all** of the following information and

return to the main office so we can ensure your credit card is processed properly. Completion of

this form authorizes **The Therapy Gym LLC** to process treatment and

consultative services provided by this facility on the credit card listed below.

**Name on card:**

**Authorizing Signature:**

**Credit card type: (circle one)**

http://t1.gstatic.com/images?q=tbn:ANd9GcTmCzeRJaJ0-enfswNXsogADTq5HpDPwBMti8DFPzgoLxPnpQpc

**Last 4 Digits of Card Number:**

**Expiration date:**

**Security Code:**

**Billing address:**

(Street Address)

(City, State, ZIP CODE)

**Home phone number:**

**Child's name:**

**Therapist's name:**

**CANCELLATION POLICY**

**Therapy Sessions:** We require at least 24 hours’ notice for cancellations. A $60.00 fee will be charged for all cancellations within 24 hours.

**Evaluations:** A credit card must be provided at the time of scheduling an evaluation and will be kept on file. There will be a $100 fee if you do not arrive at the scheduled evaluation and do not give notice. If the evaluation is canceled within 24 hours, there will be a $60 cancellation fee. 

Thank you!

Sign Date

You can now access all your documents, including evaluations, session notes, and upcoming appointments on your patient portal!

