



PATIENT REGISTRATION FORM

Patient Name:	Date of Birth:
Parent or Guardian Name:	
Address:	City: State: Zip Code:
Home Telephone:	Cell Phone:
Email:	
Patient's Doctor:	Doctor's Telephone:

Parent or Guardian Information

Employer:
Work Telephone:

Insurance Information

Primary Insurance:	
Policy#: Sponsor SS# (Tricare only):	Group#:
Name of Policy Holder:	Relationship to Patient:
Secondary Insurance:	
Policy#: Sponsor SS# (Tricare only):	Group#:
Name of Policy Holder:	Relationship to Patient:

Developmental Case History

Child's Name _____ Age: ____ Date of Birth: _____

Parent(s)/Guardian Name _____

Referral Information:

How did you hear about us: _____?

Areas of Concern:

Check all that apply

Speech/Language	
Gross Motor	
Fine Motor	
Visual Perceptual	
Visual Motor	
Sensory	
Behavioral	
Eating/Feeding	
Learning Difficulties	
Handwriting	
Other:	

What would you like to see THERAPLAY work on with your child?

Name of pre-school, daycare, or school: _____

Developmental History:

List the age when your child began: Crawling _____ Walking _____ First Words _____ Combining words _____

Did your child babble as an infant? Yes or No

Family History:

Please check all that apply.

	Maternal	Paternal
Speech Problems		
Stuttering		
Learning Disability		
Hyperactivity/Attention Problems		
Mental Retardation		
Emotional Problems/Depression		
Birth Defects		
Seizures		

Birth History:

Any complications during pregnancy? Yes No _____

Any complications immediately following birth? Yes No _____

Gestational Time: _____ Birth Weight: _____

Medical History:

Is your child current with his/her immunizations? Yes or No

Has your child been hospitalized for any reason? Yes No _____

Has your child had frequent ear infections? Yes No

Does your child have/has your child had tubes? Yes or No When? _____

Does your child have any other illness/medical problems? _____

Please list important or primary medical history or diagnosis:

Feeding/Eating History:

Did your child have any difficulties feeding after birth? If so, please explain _____

Is your child a picky eater? Yes or No _____

When did your child stop using a bottle? _____
Pacifier? _____

Play/Social Information:

Does your child play appropriately with toys? Yes or No _____

Does your child engage in any odd behaviors? Yes or No _____

Does your child have difficulty attending or concentrating? Yes or No

Does your child have any significant problems with behavior? Yes or No

Sensory/Motor Development:

Does your child appear awkward or clumsy? Yes or No

Does your child seem to dislike certain type of textures (does not like getting dressed, dislikes tags in clothes, does not like water)? Yes or No

Please list dates and types of any other evaluations
(example: neurologist, early intervention, occupational therapy, etc.) and **where?**

Insurance Agreement

Dear Parents,

Thank you for choosing THERAPLAY as your pediatric speech-language services provider. We strive to provide services that are professional, comprehensive and with excellence to all children in need of our services. For this reason, we want to ensure that all of your children's insurance services are accurate and up-to-date.

We will be responsible for billing your insurance provider for services rendered, however, depending on your policy, deductibles and/or co-pays need to be met before your provider will agree to make payments. **You, as the policy holder, are responsible for paying any deductibles and/or co-pays that may apply.** In addition, if your insurance provider denies any claims, you as the parent or guardian will be responsible for payment of these services. Any payments, in which you as the parent or guardian are responsible for, will be billed to you on a weekly basis. If you fail to make payments, your child's services will be put on hold until payments are received and your account is paid in full.

If your insurance provider is **Medicaid**, benefits will cover 100% of the payment for the evaluation and therapy. This cost is only covered if your child remains eligible for services.

We ask that all parents let THERAPLAY know when there is a change in your insurance provider and/or a renewal with your current insurance provider. You as the parent or guardian will be responsible for the payment of any services rendered if any claims are denied from your provider due to not following this policy.

As the parent or guardian, I have read the above information and understand THERPLAY's Insurance Agreement. I accept all terms and conditions.

Parent/Guardians' Name

Date

Parent/Guardian's Signature

Patient Notification of Privacy Policies

THIS NOTICE DESCRIBES HOW YOUR MEDICAL RECORDS MAY BE USED OR DISCLOSED AND HOW YOU CAN ACCESS YOUR RECORDS. PLEASE REVIEW IT CAREFULLY.

I hereby authorize use or disclosure of protected health information about my child as described below:

1. Confidential information is stored in a secure location away from public access. All computers containing confidential information are only accessed by password.
2. THERAPLAY is authorized to disclose pertinent health information to insurance companies or referring physicians for the purposes of requesting doctor's orders, authorization for service or to obtain reimbursement for services. Information may be sent via first class mail or fax with procedures in place to limit the likelihood of unauthorized access.
3. THERAPLAY and its employees are authorized to use or disclose pertinent health information that is required for speech-language therapy purposes.
4. THERAPLAY may disclose protected health information considered pertinent to Speech-language therapy to specified professionals (i.e. social workers, teachers, psychologists, physicians, therapists, etc.) with a signed release form from the parent or guardian.
5. I, the parent/guardian, may revoke this authorization by notifying THERAPLAY in writing of my desire to revoke it. However, I understand that any action already completed prior to the request to revoke this authorization cannot be reversed, and my revocation will not affect those actions.
6. This authorization expires when the client is discharged from therapy, although the Company will always use professional discretion when sharing any public health information.

*If you have any questions or concerns, please feel free to contact our Privacy Officer, Jeanine Morton at: (919) 774-1281.

Parent/Guardian's Signature

Date

Parent/Guardian's Printed Name

Child's Name



Dear Parents,

With the growth of the clinic and staff, it is important that Theraplay LLC. run effectively in order to best service all children's and parents' needs – including therapy time, renewed supplies and billing.

Effective September 1, 2010, we will be implementing some policy changes:

- 1) **Co-pays are due at the time of service.** Please consult your insurance policy to see if you have a co-pay and what the amount is. We can help you with this if you are not sure. You may pay by cash or check.
- 2) **We have updated our Cancellation Policies.** Please read the enclosed "Guidelines and Policies" form which details Emergency and Non-Emergency cancellations. Please sign the back page verifying that you have read and understand these changes. (Both parents and caregivers should be made aware of the \$40.00 charge for late cancellations.) After signing, return the form to us for your child's file; we will be happy to make a copy for your reference.
- 3) **The private pay rate has increased to \$50.00/session. We will no longer be providing free services to those in daycare settings.**

Thank you for your understanding and cooperation with making Theraplay LLC. a success for all!

Jeanine Morton and staff

Guidelines and Policies

Dear Parents,

The policies written below are designed to improve our ability to see all of our clients and to provide complete, consistent treatment for your child. We hope that these policies will improve our overall service. Since continuity of care is important to maximize the outcomes of your child's therapy, we use the following guidelines for your appointments:

The Therapy Time

Your child is scheduled for a 30 or 45 minute therapy session with our staff. The last few minutes of each session is used to discuss progress and current needs related to your child. We welcome your feedback on each session so that we may continuously enhance the effectiveness of their program.

We ask that you:

- Arrive on time. You (the parent or caregiver) must be present in the waiting room during the last 5 minutes of the session to discuss your child's session and any homework.
- Please make sure that we have your current contact information if you leave the building in the event of an emergency or need to be reached.
- If you bring a sibling, they are not allowed on any equipment used for therapy purposes because of liability issues. Please keep them under supervision in the waiting room. We have provided toys/books to entertain the siblings during this time. Please help us keep the area safe and tidy.
- Please refrain from eating messy foods and drinking messy beverages in our waiting room. Any spills are your responsibility and you will be charged accordingly. Water and dry snacks only are allowed in the waiting room. Also, please **NO PEANUT** or **NUT** products in the waiting room due to potential allergies of other clients.
- You will be financially responsible for any damage by your child to any therapy/office item. Payment for items is required prior to (or at) your child's next therapy session.

Emergency Cancellations: Cancel by 8:00am

Emergency cancellations are due to illness, death in the family or illness of a family member. To avoid the \$40.00 cancellation fee (per service); please contact Theraplay by phone, (919)774-1281, by 8:00am that morning. (This fee is the parent's responsibility and cannot be billed to insurance.)

Non-Emergency Cancellations: 24 Hours Notice

This includes vacations, pre-planned doctor's appointments, family events, parties, sporting events, lack of babysitter, etc. This includes anything not designated "emergency" (see above). The session must be cancelled with at least 24 hours notice. If the session is not cancelled with 24 hours notice, you will incur a \$40.00 cancellation fee (per service). If cancellations become excessive for non-emergency purposes, then the child may lose his/her weekly slot in the therapy schedule. If you have three consecutive cancellations of your child's appointments within a 6 month period, you will lose your standing appointment time slot. You and your child's primary care physician will be notified by phone or letter.

If you are going to be late for a scheduled appointment, please call and let us know. If you are more than 15 minutes late for an appointment, the appointment may be cancelled by the therapist. If you are seen, your session will end at the regularly scheduled time.

Sick Child Guidelines:

Therapy is fun, but can be exhausting for your child. We want our patients to be productive in therapy as much as possible. Please use your best judgment and the following guidelines for making the decision to keep your child home from therapy.

- If your child is too ill to attend school or daycare, their therapy appointment should be cancelled. Please call by 8:00am as stated above.
- If your child has had diarrhea or has vomited, he/she must stay home for 24 hours after the episode.
- If your child has pink eye, he/she must be on medication for 48 hours prior to returning to therapy.

- If your child has a rash of unknown cause, please check with your physician before returning to therapy.
- If lice are found on your child, he/she must not return until 24 hours after the first treatment of a product such as Rid or Nix.
- If your child has chicken pox, they must stay home a minimum 7 days after the first appearance. The crust must be dry.

Please feel free to speak with Jeanine about any concerns you have about these policies or to discuss changing your regularly scheduled appointment time if you know that your current scheduled time is not optimal. We will do everything possible to provide you with a time that is consistently available for both you and your therapist. Thank you for your cooperation.

Patient's Name. _____

Parent/Guardian Signature. _____

Witness. _____

Today's Date. _____



Directions to THERAPLAY located at 135 Chatham St. Sanford, NC 27330
Phone: (919) 774-1281

From Fayetteville:

Highway 87 North to Sanford.

Go down Horner Blvd. to the downtown area.

Right on Wicker Street

Left on Chatham Street

We are the 4th building on the right.

From Lillington/Dunn:

421 South toward Sanford

Stay on Horner Blvd. to the downtown area.

Right on Wicker Street

Left on Chatham Street

We are the 4th building on the right.

From Carthage/Pinehurst:

15/501 North or US 1 North

Take the NC-42 exit toward Asheboro/Fuquay-Varina

Right on NC-42/Wicker Street

Left on Chatham Street

We are the 4th building on the right.