THE CENTER FOR PEDIATRIC THERAPY
Speech, Occupational, & Physical Therapy

Physical Therapy
Occupational Therapy
Speech Therapy

Dear Parents:

Thank you for choosing The Center for Pediatric Therapy, LLC for your child's evaluation and treatment. Your child, _____, has an appointment scheduled on _____ at _____ am/pm with _____ (therapist). If you cannot keep this appointment, please notify us within 24 hours so that we can reschedule your child's appointment.

We are honored to be able to help your child and family achieve your goals. In order to help all of us develop the best working relationship possible, we would like to begin with clear communication about our business regarding our responsibilities to you, our clinical/business practices, business policies and clinical expectations. In this packet, you will find our business policies for you to read and sign. Copies of the signature pages will be made by your therapist for your child's chart, and the rest of the paperwork will then belong to you. We encourage you to keep this information handy at home, so you will know how and when to reach us. Also included in this packet are forms for you to provide information about your child's medical, developmental, and sensory history. Please complete these forms with as much detail as possible, as this information will be important to your therapist when evaluating and developing a plan of care for your child.

INFORMATION FORMS IN THIS PACKET:

- Patient Information Sheet
- Billing Policy
- Credit Card Authorization Form
- Cancellation Policy
- Notice of Privacy Practices
- Patient Rights and Responsibilities
- Consent for Secure/Release of Information
- Allergy Notification
- Medical and Developmental History

We hope the information in this packet will be informative. Please read all pages thoroughly, sign any forms where appropriate, and bring the completed forms to your child's scheduled appointment. We look forward to working with you and your child.

Thank you!

The Center for Pediatric Therapy, LLC

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Billing Policy

The Center for Pediatric Therapy, LLC is committed to providing you with the best therapy available. Our ability to continue to provide treatment to your child is dependent on timely payment for services rendered. We have created this Billing Policy to clearly communicate with you the various responsibilities of our business and yourself regarding reimbursement for your child's treatment.

- A current prescription is required from your physician.
- "In-Network" Patients: All deductibles, co-payments/co-insurance, and/or other payments are due at the time of service. Pre-certification does not guarantee benefits or eligibility. As clinical providers being contracted with your insurance company, we have taken the responsibility of filing your charges directly to your insurance company. Some services may be denied by your insurance company secondary to plan, medical necessity, or other policy limitations. We will attempt to re-file a denied claim on your behalf one time. If your claim is denied again, **you are responsible for payment in full of all services denied or not covered by your insurance.**
- "Out-of-Network" Patients: A portion of your payment must be made at the time of service. Contacting the insurance company to ask specific questions regarding your insurance coverage allows you to make an informed decision based upon the information provided regarding coverage and exclusions. The patient is ultimately responsible for being the primary communicator with their insurance company for all claims filed. As a courtesy, The Center for Pediatric Therapy, LLC will file charges directly to your insurance company. The patient is responsible for all charges not covered by insurance. Keep in mind that all insurance companies issue a disclaimer stating that the information that they give you is NOT A GUARANTEE of benefits. Therefore, The Center for Pediatric Therapy, LLC also cannot guarantee that your insurance carrier will reimburse services. **You are responsible for payment in full of all services denied or not covered by your insurance.** If CPT does not receive payment from your insurance company within 90 days, you will be responsible for payment in full. ***** Please note that some patients may be able to get approved at an "in-network" benefit level if there are no other providers providing the same services in the area. Since CPT does not have a contract with these companies, the same payment policy will be followed for "Out-of-Network" benefits.
- For Self-Payment: Payment is due in full at the time of service.
- For your convenience, CPT requests that all patients have a credit card on file to cover any charges you may be responsible for.
- **For services rendered at school, a credit card must be authorized for payment on the day of service. A credit card must be kept on file, this is mandatory if your child is seen at school. A $5.00 travel charge will be applied to all children seen at school.**
- **All appointments missed without contacting the office 24 hours before your child's scheduled appointment (please refer to *Cancellation Policy*) will be charged $65.00.**
- Payments: Payment for services can be paid by cash, check, or credit card. Checks must be made to *The Center for Pediatric Therapy*. All charges associated with the collection of this bill become the responsibility of the responsible parties.
- NSF checks are charged a $25.00 service fee.
- Any accounts 30 days past due will begin accruing a **30%** monthly late fee on total balance due until past due balance is paid in full.
- After 60 days we will reserve the option to either contact the in-house collections department and/or discontinue services until the account is paid in full.
- **Any accounts 90 days past due may be handed over to our collection agency.**

By signing this agreement, I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I have read and understood the information presented and I agree to the above policy procedures. Therapy will be initiated when the responsible parties have signed this agreement.

Child's Name: _____ Date of Birth: _____

Parent Signature: _____ Date Signed: _____

Parent Name: _____

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Assignment of Benefits and Consent for Treatment
Acknowledgement of Policies and Procedures

I authorize the release of all medical and/or further information necessary to process all claims pertinent to my medical care for services rendered by The Center for Pediatric Therapy, LLC.

I authorize treatment and procedures to be performed by The Center for Pediatric Therapy.

I authorize payment of medical benefits to The Center for Pediatric Therapy, LLC for services rendered and understand that my insurance plan does NOT GUARANTEE payment of my bill.

My signature below acknowledges that I understand that I am financially responsible and accept liability for all charges incurred at The Center for Pediatric Therapy, LLC.

By signing this form, I acknowledge that I have received a copy and am in agreement with The Center for Pediatric Therapy, LLC's Notice of Privacy Practices, Billing Policy, Cancellation Policy, and Consent for Release of Information.

Patient Name: _____ **Date of Birth:** _____

Parent/Guardian Signature: _____

Parent/Guardian Name: _____ **Date:** _____

Notice of Privacy Practices

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

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, therapist, and other health care personnel that are involved in your care and treatment for the purpose of providing health care services to you, to support the operations of the practice, and any other use required by law.

Treatment: Your protected health information will be used and disclosed to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Healthcare Operations: Your protected health information will be used or disclosed, as needed, in order to support the business activities of the practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. Your health information may be reviewed during the routine processes of certification, licensing, or credentialing activities.

Patient Reminders: Because consistent care is very important in your therapy, you will be reminded of scheduled appointments or that it is time for you to schedule a parent conference. These communications are an important part of the philosophy of partnering with clients to be sure they receive the best care possible. They may include postcards, letters, telephone reminders or electronic reminders such as email (unless you inform the office that you do not want to receive these reminders).

Abuse or Neglect: Government authorities will be notified if it is believed that a patient is the victim of abuse, neglect, or domestic violence. This disclosure will be made only when I am compelled by ethical judgment, when I believe I am specifically required or authorized by law, or with the patient's agreement.

Public Health and National Security: It may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment, or medical device.

Law Enforcement: As permitted or required by State or Federal law, your health information may be disclosed to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are the victim of a crime or in order to report a crime.

Family, friends, and caregivers: With your permission, your health information may be shared with those you tell us will be helping with your therapy program or payment. I will be sure to ask your permission first. In the case of an emergency, where you are unable to communicate what you want, best judgment will be used when sharing your health information only when it will be important to those participating in providing your care.

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CANCELLATION AND ATTENDANCE POLICY

Our cancellation and attendance policy is designed to improve our ability to see all patients, and to provide complete, consistent treatment for your child.

If you know that you are going to miss an appointment, you must notify the office 24 hours before the scheduled appointment. Failure to notify the office within 24 hours will result in a **$65 charge**. This fee must be paid prior to your child's next scheduled appointment. Please be aware that insurance will not pay for missed visits.

If you know that your child will be absent from school on the day that the therapist is scheduled to attend his/her school, you must notify the office 24 hours before the child's scheduled appointment. Failure to notify the office within 24 hours will result in a **$65 charge**.

If you must cancel your child's appointment less than 24 hours in advance due to illness, you must contact our scheduling department for our office to determine if your child can be seen that day.

We ask that your child be free of fever 24 hours prior to resuming therapy.

Please remember that being guaranteed a time slot on the schedule is determined by consistent attendance. If your child's attendance becomes inconsistent, your child will no longer be guaranteed a regular time slot.
Please feel free to speak with your therapist about changing your regularly scheduled appointment time if you know that your current scheduled time is not optimal.

Continuity of care is important to maximize the outcomes of your child's therapy. We appreciate your cooperation.

Signature _____

Name _____ **Date** _____

Patient Rights

Following is a statement of your rights with respect to your protected health information.

Restrictions: You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations.

Confidential Communications: You have the right to request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Inspect and Copy your Health Information: You have the right to inspect and copy your protected health information, including your chart and billing records. If you would like a copy of your health information, please let me know. I may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend your Health Information: You have the right to ask me to update or modify your records if you believe your health information records are incorrect or incomplete. I will be happy to accommodate you as long as our office maintains this information. In order to standardize the process, please provide me with your request in writing and describe your reason for the change. Your request may be denied if the health information records in question were not created by my office, are not part of my records, or it the records containing your health information are determined to be accurate and complete.

Documentation of Health Information: You have the right to ask for a description of how and where your health information was used by the office for any reason other than for treatment, payment, or health operations. Documentation procedures will enable me to provide information on health information usage from your initial visit and forward. Please let me know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. I may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice: You have the right to obtain a copy of this ***Notice of Privacy Practices*** directly from the office at any time. Give me a call, and I will mail or email a copy to you. I am required by law to maintain the privacy of your health information and to provide to you and your representative this Notice. I am required to practice the policies and procedures described in this notice but I do not reserve the right to change the terms of our Notice. If I change the privacy practices, I will be sure that all patients receive a copy of the revised notice.

Complaints: You have the right to express complaints to me or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. I encourage you to express any concerns you have regarding the privacy of your information. Please let me know of your concerns or complaints in writing.

Patient Rights and Responsibilities

Summary of Patient's Rights:

- The right to considerate, confidential, private, and respectful care.
- The right to understandable information about your diagnosis and possible treatments.
- The right to know the name, role, and credentials of the people treating you.
- The right to privacy of treatment records unless you have given permission to release information.
- The right to review your treatment records and to have the information explained.
- The right to know if The Center for Pediatric Therapy, LLC has relationships with outside parties that may influence your care.
- The right to give consent or decline any part of treatment. If you choose not to take part, you will receive the most effect care The Center for Pediatric Therapy, LLC otherwise provides.
- The right to know about any office policy that affects you and your treatment.
- The right to an itemized bill of charges and payments.
- The right to a quick response regarding any comments, questions, or complaints.
-

Summary of Patient's Responsibilities:

- The responsibility to be prompt for all scheduled appointments.
- The responsibility of notifying The Center for Pediatric Therapy, LLC 24 hours in advance of cancellation.
- The responsibility of providing any information regarding previous evaluations, or health issues such as allergies or special diets.
- The responsibility of providing The Center for Pediatric Therapy, LLC with correct and/or update information regarding address, telephone, change of custody status.
- The responsibility of asking questions when you do not understand instructions or information.
- The responsibility to notify your therapist if you are unable or unwilling to follow therapy recommendations.
- The responsibility of being considerate of the needs of other patients.
- The responsibility to assure appropriate behavior of all non-patient visitors brought to the office.
- The responsibility to pay fees for services received at the time of treatment.
- The responsibility to arrive 10 minutes before therapy ends to pick up your child from his/her therapy session

Consent for Secure/Release of Information

Patient Name: _____ **Date of Birth:** _____

Address: _____

I/We hereby authorize and request The Center for Pediatric Therapy, LLC to secure and/or release medical, social, educational, and other clinical information regarding the patient named above. I/We understand that this authorization may be revoked in writing at any time. Otherwise this consent automatically expires two years from the date of the signature. **This authorization applies only to the following individuals/institutions: If not completed, no information will be released from the office.**

Primary Care Physician: _____

Address: _____

Name: _____

Address: _____

Name: _____

Address: _____

I/We give permission for The Center for Pediatric Therapy, LLC to disclose/request information regarding scheduling of school based appointments, therapy, school performance, and/or any information deemed relevant to academic therapy success to:

School Name: _____
This includes the principal(s), counselor(s), and all teachers involved with the named student.

I/We give permission for The Center for Pediatric Therapy, LLC to communicate via email, information, i.e. evaluations, therapy updates, and/or other clinical information regarding the patient listed above. Information will not be disclosed to anyone not specifically listed below.

Email Address: _____ Email Address: _____

I hereby further direct that a copy of this authorization shall be deemed to be as valid as the original for all purposes authorized herein.

Parent/Guardian Signature: _____

Parent/Guardian Name: _____ **Date:** _____

ALLERGY NOTIFICATION

From time to time your child's therapist may utilize examination gloves and various foods in the course of therapy to assess or stimulate certain oral motor and sensory skills. We are aware of the fact that some children are allergic to the materials used in examination gloves and may be on specialized diets or have food allergies. Please read the following list carefully and indicate any allergies you know your child has. Please list any other known allergies in the space below. This information will be noted in a prominent place in your child's chart. Please keep your child's therapist informed of any allergic reactions that are identified in your child over the course of his therapy program. Your child's health and safety are of the upmost importance to us!

The following are some of the foods and substances commonly used in therapy. Please tick any that your child is allergic to OR which are not a part of your child's special diet:

- ☐ Latex
- ☐ Talc (powder)
- ☐ Peanut Butter
- ☐ Pretzels
- ☐ Chocolate
- ☐ Smarties
- ☐ Apple Sauce
- ☐ Gummie bears/twizzlers
- ☐ Pudding
- ☐ Canned fruit (peaches, pears, fruit cocktail, etc)
- ☐ Canned vegetables (corn, beans, etc)
- ☐ Hard candy (lollipops)
- ☐ Butter cookies
- ☐ Cheetos (cheese puffs)
- ☐ Lemon juice
- ☐ Dried Cereals (fruit loops, etc)
- ☐ Powdered sugar (in small amounts)
- ☐ Bubble gum
- ☐ Taffy
- ☐ Jell-o
- ☐ Raisins

Please list **ANY** other known allergies:

_____

Is your child on a special diet? ☐ Yes ☐ No If yes, what type? _____

If your child has no known allergies, please write "NO KNOWN ALLERGIES" in the blank below before signing this form:

_____

I have provided the information above to the best of my knowledge at the request of The Center for Pediatric Therapy, LLC and my child's therapist. I will be responsible for notifying CPT and my child's therapist of any change in the status of the above information.

Child's Name: _____ **Date of Birth:** _____

Parent's Signature: _____

Parent's Name: _____ **Date:** _____

MEDICAL AND DEVELOPMENTAL HISTORY
PART 1 - GENERAL INFORMATION

CHILD'S FULL NAME: _____ DATE OF BIRTH: _____

HOME ADDRESS: _____

HOME PHONE: _____ MOM CELL:_____ DAD CELL:_____

EMAIL ADDRESS:_____

FATHER'S NAME: _____ OCCUPATION: _____

WORK #: _____ EMPLOYER:_____ SSN:_____

MOTHER'S NAME: _____ OCCUPATION:_____

WORK #: _____EMPLOYER:_____ SSN:_____

CHILD RESIDES WITH: ___ Mother and Father ___ Mother ___ Father ___ Other

OTHER PERSONS LIVING IN THIS CHILD'S HOUSEHOLD:
NAME_____ SEX _____ AGE _____ RELATIONSHIP TO CHILD ____

_____

_____

_____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

PHONE NUMBER(S):_____

SCHOOL: _____ GRADE: _____

TEACHER'S NAME: _____ TYPE OF CLASSROOM: _____

REFERRED BY:_____

REASON FOR REFERRAL: _____

NAME OF PROFESSIONALS YOUR CHILD HAS SEEN AND HOSPITAL/OFFICE AFFILIATED WITH:
PEDIATRICIAN:_____

NEUROLOGIST: _____

ENT:_____

GASTROENTEROLOGIST:_____

OPTHAMOLOGIST:_____

PSYCHIATRIST/PSYCHOLOGIST:_____

OCCUPATIONAL THERAPIST:_____

PHYSICAL THERAPIST:_____

SPEECH THERAPIST:_____

GENETISIST: _____

ORTHOPEDIST: _____

OTHER:_____

PART 2: PREGNANCY AND BIRTH HISTORY

PRENATAL HISTORY:

1. Did you have any infections/illnesses during pregnancy? _____ Yes _____ No
   Please describe: _____
2. Did you have any unusual stresses or shocks during pregnancy? _____ Yes _____ No
   Please describe: _____
3. Did you receive any medication during pregnancy? _____ Yes _____ No
   Please describe: _____
4. Did you have any complications during delivery/labor? _____ Yes _____ No
   Please describe: _____

BIRTH HISTORY:

1. Was the child born _____ full term or _____ premature?
2. Number of weeks: _____ Weight at birth: _____
3. Was labor induced? _____ Yes _____ No If yes, reason for induction _____
4. What type of delivery? ☐ Vaginal ☐ Cesarean Section = elective or emergency _____

Presentation: ☐ Head ☐ Face ☐ Breech ☐ Transverse Assistance: ☐ Forceps ☐ Suction ☐ other _____

5. Did the child have any birth injuries? _____ Yes _____ No Describe: _____
6. What was the baby's APGAR scores? 1 minute _____ 5 minutes _____
7. Did the child require intensive care hospitalization? _____ Yes _____ No How long? _____
8. Was the child jaundiced? _____ Yes _____ No Length of treatment _____
9. Did your child pass the newborn hearing test? _____ Yes _____ No

PART 3: MEDICAL HISTORY OF CHILD

It is very important to have as complete a medical history for your child as possible. Please fill out the grid below, making sure you include an explanation for any question answered "yes". In your explanation, please include your child's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Frequent Colds/Respiratory Illness	
2			Frequent Strep throat/sore throat	
3			Frequent Ear Infections (Tubes in ears?)	
4			Birth defect/genetic disorder	
5			Lung condition/respiratory disorder	
6			Allergies or asthma	
7			Heart condition	
8			Anemia/blood disorder	
9			Kidney/Renal disorder	
ITEM	**NO**	**YES**	**DESCRIPTION**	**EXPLANATION**

10			Urinary problems/infections	
11			Hormonal problem	
12			Muscle disorder/muscle problem	
13			Joint or bone problems	
14			Fractured bones	
15			Skin disorder/skin problems (eczema)	
16			Visual disorder/vision problems	
17			Eye infections	
18			Neurological disorder	
19			Seizures or convulsions	
20			Stomach disorder/stomach pain	
21			Vomiting/digestion problems	
22			Reflux	
23			Food Allergies/Intolerances	
24			Failure to gain weight/feeding problems	
25			Constipation/diarrhea problems	
26			Dehydration episodes	
27			Hearing Loss/Ear disorder	
28			Significant accidents	
29			Head injuries or concussions	
30			Ingestion of toxins, poisons, foreign objects	
31			Major medical procedures (detail below)	
32			Chronic medications (for what? when?)	
33			Any major childhood illness (pox, croup, measles, mumps, meningitis etc)	

Has the child ever been hospitalized or had any surgeries? _____ Yes _____ No
If yes, when, where, & why: _____

_____

_____

Please note any medications and/or vitamin supplements your child is currently taking, the dosage, and intended purpose: _____

_____

Has the child received any medications in the past for any of the above mentioned conditions? _____

_____

Has the child received previous evaluation and/or treatment by an occupational, speech-language, and/or physical therapist(s)? _____ Yes _____ No
If yes, where and dates of treatment: _____

Has the child received previous evaluation and/or treatment by any other health professionals (orthopedics, psychologist/psychiatrist, developmental pediatrician, neurologist, etc)? _____ Yes _____ No

If yes, please list:

Date Type Professional's Name Dates of last visit

_____
_____
_____
_____
_____

Does the child have a medical diagnosis? _____ Yes _____ No If yes, describe:_____

Has the child had a vision test? _____ Yes _____ No If yes, when and describe results: _____

Has the child had a hearing test? _____ Yes _____ No If yes, when and describe results: _____

Are there any medical precautions your therapist should be aware of when working with your child? _____

_____

PART 4: DEVELOPMENTAL HISTORY

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following INDEPENDENTLY. If you can not recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time or late. If your child has not yet achieved the milestone, write NA in the age column.

MILESTONE	AGE	EARLY	ON TIME	LATE	COMMENTS
Smiled					
Rolled over					
Sat unsupported					
Crawled					
Stood alone					
Walked by self					
Said first words					
Said 2-3 phrases					
Ate solid foods					
Drank from an open cup					

Do you feel your child was "faster" or "slower" than his/her peers in any other way? Please explain _____

_____

Did your child have colic?_____ Yes _____ No for how long?_____

Did your child dislike lying on stomach as an infant? _____ Yes _____ No

Did your child dislike lying on back as an infant? _____ Yes _____ No

Did your child become calmed by car rides or infant swings? _____ Yes _____ No

Has your child had problems with any of the following (beyond expected for child's age):

NO	YES	DESCRIPTION	EXPLANATION
		Sleeping problems	

		Feeding Problems	
		Bed wetting	
		Potty training	
		Drooling	
		Thumb sucking	
		Temper tantrums	
		Head banging	
		Aggression/destructiveness	
		Major mood swings	
		Under or over reactive to sounds	
		Under or over reactive to touch	
		Under or over reactive to taste	
		Under or over reactive to smell	
		Any unusual fears?	

Developmental Skills: Please keep in mind that, depending on your child's age, some areas may not be achieved until a later /older age.

CAN YOUR CHILD:	**NO**	**YES**	**EXPLANATION**
Turn pages of a book			
Play with puzzles: single pieces			
Play with puzzles: several interlocking pieces			
Hold arms/legs up for dressing			
Undress self independently			
Dress self independently			
Tie shoes			
Eat with a spoon/fork independently			
Drink from an open cup without spilling			
Manipulate buttons independently			
Manipulate snaps/buckles independently			
Manipulate zippers independently			
Put on shoes and socks independently			
Climb on and over objects			
Jump with both feet together			
Ride a tricycle while pedaling with feet			
Build with blocks / Lego's			
Blow bubbles			
Blow whistles			
Suck through a straw			
Draw lines and circles			
Turn door handles independently			
Open lunch containers/bags/ or unwrap paper			
CAN YOUR CHILD:	**NO**	**YES**	**EXPLANATION**
Pump self on swing			
Blow nose independently			

Kick a ball			
Hop on one foot			
Wipe self after toileting			
Color inside lines			
Cut with scissors			
Ride a bike with training wheels			
Ride a bike without training wheels			
Skip with both feet			
Cut with a knife			
Snap fingers			
Swim using the crawl or other strokes			

CAN YOUR CHILD:	**NO**	**YES**	**EXPLANATION**
Smile when spoken to			
Respond to a sound/name			
Imitate facial expressions/speech sounds			
Understand you when you talk			
Follow directions			
Maintain eye contact			
Recognize words for common items			
Point to common objects			
Identify body parts			
Answer simple “Wh” questions			
Enjoy listening stories read aloud			
Understand “No”			
Recognize familiar people			

Wave bye-bye			
Make speech sounds			
Combine sounds			
Imitate adult like speech sounds			
Use speech intentionally			
Imitate/Use words			
Request and/or Protest			
Combine words			
Ask questions			
Label objects, people, and/or body parts			
Hold a conversation			
Take turns			

HEARING	**NO**	**YES**	**EXPLANATION**
Had a recent hearing test, if yes by whom, where , and results			

Had recurrent ear infections			
Had placement of Pressure Equalization tubes, if yes by whom, when, & how many			
Utilize an assistance listening device			

SWALLOWING/FEEDING	NO	YES	EXPLANATION
Did your child breast feed, if yes how long			
Did your child bottle feed, if yes how long			
Did your child take a pacifier, if yes how long			
Does your child open his/her mouth when a spoon is presented			
Does your child drink from an open cup			
Does your child suck through straw			
Does your child feed him/her self with fingers			
Does your child feed him/her self with utensils			
Does your child blow bubbles			
Does your child lick ice cream or a lollipop			
Does your child eat solid food			
Is your child a picky eater			
Does your child choke or gag on food			
Has your child ever had a Modified Barium Swallow Study, if yes, by whom and results			

CAN YOUR CHILD	NO	YES	EXPLANATION
Recognize letters of his/her name			
Recognize letters of alphabet			
Recognize sounds of alphabet			
Recognize numbers, shapes, & colors			
Recognize sight words			
Read picture books			
Read story books			
Understand what is read			
Write name			

Answer each question with as much detail as possible. Add any additional information that you feel may be helpful.

How does your child communicate wants and needs?

How does your child get your attention?

Do other people find it difficult to understand your child's speech?

How does your child play with other children?

Explain in detail your child's current diet.

Describe your child's sleep patterns?

Explain in detail how your child spends the majority of his/her day.

Please list or describe activities that your child finds easy and enjoys:

Please list or describe activities that your child finds most difficult / least enjoys: _____

_____

_____

Is your child involved in any extra-curricular activities (i.e. swimming, karate, gymnastics, etc.)? _____

_____

_____

If your child is enrolled in school, does he/she have any difficulty with the following? (Please tick)

☐ Reading	☐ Math	☐ Spelling	☐ Remembering Information
☐ Finishing Tasks	☐ Paying Attention	☐ Handwriting	
☐ Organizing Work	☐ Restlessness	☐ Following Directions	

Please describe any concerns with fine motor and/or gross motor skills, communication, social skills, academic skills, sensory issues: _____

_____

_____

What do you hope to gain from this evaluation and/or treatment? _____

_____

_____

Signature of Person Completing Form: _____ Date: _____

Name of Person Completing Form: _____

Relationship to Child: _____

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The Center for Pediatric Therapy understands that you may not always be available to bring your child to therapy. We would like you to list possible person(s) who will be dropping off or picking up your child and if you would like the therapist to give any information about your child's therapy progress.

Possible people dropping off or picking up your child: **permission to discuss progress**

1. _____ Phone: _____ --Select--

2. _____ Phone: _____ --Select--

3. _____ Phone: _____ --Select--

Child's Name: _____

Parents Signature: _____

Parents Name: _____ Date: _____

Consent to change my child

☐ **If I leave during my child's therapy session I give permission for their therapists to change my child if they have an accident.**

☐ **I do not give permission for my child's therapists to change my child if I am not here.**

Multimedia Permission

I give my consent for The Center for Pediatric Therapy to photograph or video my child or to use photographs or videos that already exist of my child that were taken in the clinic setting. I understand that the photographs, digital images, or video segments may be used in print or electronic media and that the photographs may be displayed on websites owned or sponsored by The Center for Pediatric Therapy (i.e., Facebook, Instagram). I give The Center for Pediatric Therapy permission to publish, exhibit, and distribute these materials for educational, research, development, public service, advertisement, and/or training purposes. I understand that The Center for Pediatric Therapy owns the copyright to the multimedia material in which my child may appear. The Center for Pediatric Therapy will assure that all media convey positive images of the child and reflect childhood recommended practice.

Please complete a separate form for each child.

Permission for Child:

_____
Name of Child (print)

_____
Parent/Guardian Name (print)

_____
Signature of Parent/Guardian

_____
Date

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