TOTS Registration Packet

Patient Information

Date:_____ Where did you hear about us?:_____

Child's Name: _____

Child's Date of Birth:_____ Child's Social Security #:_____

Child's Address:_____

City/State/Zip: _____

Home Phone:_____

Mom's Name: _____ Dad's Name: _____

With Whom does the Child Reside?: _____

Mom's Occupation: _____ Employer: _____

Wk Phone: _____ Cell Phone: _____

Email: _____

Dad's Occupation: _____ Employer: _____

Wk Phone: _____ Cell Phone: _____

Email: _____

Mom's Social Security #_____ Dad's Social Security # _____

Mom's Date of Birth: _____ Dad's Date of Birth: _____

Primary Care Physician: _____

Address: _____

City/State/Zip: _____

Phone: _____

Primary Insurance: _____

Claims Address: _____

Customer Service Phone Number: _____

Fax Number: _____ Email: _____

Insured's Name: _____ ID#: _____

Policy#: _____ Group#: _____

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Case History Form

Child's Name: _____ Sex: M or F Date of Birth:_____

Parent's Name(s): _____

Referred by: _____ Primary Physician: _____

Does your child attend preschool or school? Yes No

School Name: _____ Teacher's Name: _____ Grade: _____

Is child receiving school based therapy? Yes No If so please list: _____

Pre-Natal/Birth History

What pregnancy was this child (1st, 2nd, etc)? _____ Birth Weight: _____

Were there any complications, illnesses and/or accidents during the pregnancy? Yes No

If yes, please describe: _____

_____

Were there any complications with the birth or shortly after? Yes No

If yes, please describe: _____

_____

Other Children in the family: Name Age Grade Disability

_____

_____

_____

_____

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Early Development

Does the child have difficulty with any of the following:

_____ Swallowing _____ Chewing _____ Drooling

If yes, please describe:

_____

At what age did the child: Sit Alone_____ Crawl _____ Toilet Trained _____ Dress Self _____

Do you feel the child is well coordinated? Yes or No What is the child's dominant hand? Right or Left or Unknown

Medical History

List below all major illnesses, accidents, and operations which the child has had.

Illness Age Duration Severity Outcome

_____

_____

_____

Please check yes or no. If yes, please describe.

Information	Yes	No	Description
Family history of learning/neurological disorder			
Child takes medication regularly			
Child has a hearing problem			
Child had hearing test recently			
Other significant medical concerns			

Speech/Language History

What is the primary language spoken in the home?:_____

Did the child babble and coo as an infant? _____ Yes _____ No

What mode(s) of communication does your child primarily use?

____ verbal _____non-verbal _____ signs _____ gestures _____ communication device

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Please circle which of the following best describes your child's vocabulary:

0-5 words/signs	5-10 words/signs	10-20 words/signs	20-50 words/signs	50 + words/signs	100 + words/signs

Please fill out the following information on the age your child began using language.

Acquisition of Words/Signs	Age	Examples of Words/Sentences/Signs
1st word		
Combining 2 words		
2-3 word phases		
Sentences		

Did speech and language ever seem to stop for a time? Yes or No

Is the child aware of the problem? Yes or No

Please describe your concerns: _____

_____

_____

Pleas list the child's interests and/or what makes them happy: _____

_____

_____

Please indicate your goals for therapy: _____

_____

_____

_____

Does your child have any behavioral difficulties? If so, please specify: _____

_____

_____

Please provide any additional information that may be helpful in working with your child:_____

_____

_____

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For OT and PT Concerns please check areas in which your child has difficulty or needs help:

Fine Motor Skills: □ Management of clothing fasteners □ Ability to tie shoes □ Scissors skills □ Pencil grasp □ Coloring accuracy □ Ability to open snack and drink containers □ Sharpening pencil	Functional School Skills: □ Management of clothing in bathroom □ Management of coat/mittens/hat □ Management of backpack/lunchbox □ Walks with tray in cafeteria □ Ability to handle transitions
Body in Space Skills: □ Ability to stay seated in chair □ Sitting tolerance on floor □ Waiting/walking in line □ Navigating playground □ Space between self and others in line	Visual Motor/Visual Perceptual: □ Legibility of handwriting □ Fluidity of handwriting □ Ease of getting thoughts on paper □ Quality of drawings □ Quality of pencil pressure □ Frequency of letter/ Number reversals
Sensory Processing Skills: □ Tolerance of noise □ Tolerance of tactile sensations □ Tolerance of movement □ Engages on self-stimulatory behavior □ Ability to plan new movement patterns	Activities of Daily Living: □ Help with dressing □ Shoe tying □ Hair combing, tooth brushing □ Eating with/without utensils □ Bathing □ Toileting/potty training
Gross Motor Skills: □ Difficulty with running, jumping, hopping □ Difficulty with ball skills: catching, kicking □ Poor sitting balance in chair, on floor □ Poor performance in physical education classes □ On playground fatigues easily/becomes short of □ breath	Equipment: □ Needs training in wheelchair propulsion □ Needs positioning equipment for sitting, feeding □ Uses walker, crutches, foot/leg, orthotics □ Equipment in need of repair
Gait/Balance: □ Difficulty walking: awkward gait, walks on toes □ Falls frequently □ Difficulty with stairs on bus, curbs, etc □ Needs assistance to walk □ Uses assistive devices _____	Developmental Milestones: □ Held head up at _____ months □ Sat at _____ months □ Rolled over at _____ months □ Crawled at _____ months □ Pulled to stand at _____ months □ Walked at _____ months

Consent for Communication via Electronic Mail

I give my consent for Theracare Outpatient Therapy Services (TOTS) business office staff to communicate with me via email in regard to my child's account and insurance coverage.

By providing this email address the providers and staff at TOTS will assume that they are communicating ONLY with the legal parent or legal guardian of the patient named on the consent form. Once the information to be communicated is sent to the provided email address, the legal parent/legal guardian of the patient will be responsible for maintaining the security of the information. The legal parent/legal guardian must recognize that the information transmitted cannot be considered secure and that there is some risk to the patient that their personal protected health information may be accessed by others.

Email questions regarding billing and financial questions will be answered within 48 hours. All questions regarding care and health of your child should be directed to the Director of Outpatient Therapy Services.

Communication via email is intended for insurance, billing matters, and scheduling only.
TOTS does not provide any medical advice or treatment via email.

Note: Signature for acceptance of this policy will be made on the general consent form

Patient Information Consent Form

I have read and fully understand Theracare Outpatient Therapy Services (TOTS) Notice of Information Practices. I understand that TOTS may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the corporation. I also understand that TOTS will consider requests for restriction on a case by case basis, but does not have to agree to requests to restrictions. I hereby consent to the use and disclosure of my personal health information for purposes noted in TOTS Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the corporation in writing at any time.

Patient Name (Print)	Date
Signature	Date
Printed Name of Patient or Guardian (if under 18)	Date
Signature of Parent or Guardian (if under 18)	Date

I also authorize TOTS to use my protected health information for targeted marketing and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

Patient Name (Print)	Date
Signature	Date
Printed Name of Patient or Guardian (if under 18)	Date
Signature of Parent or Guardian (if under 18)	Date

Notice of Patient Information Practices (HIPAA)

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

Theracare Outpatient Therapy Services (TOTS) is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

TOTS uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, TOTS may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. TOTS may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law. In any other situation, TOTS policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. TOTS will consider all such requests on a case by case basis, but the corporation is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that TOTS may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Director of Outpatient Therapy Services at the address listed below. You may also send a written complaint to the US Department of Health and Human Services.

For further information on TOTS health information practices or if you have a complaint, please contact the following person:

Melanie Witkowski, MS, OTR
Director of Outpatient Therapy Services
Theracare Outpatient Therapy Services
9957 Allisonville Road
Fishers, IN 46038
Ph: (317) 903-9675 Fax: (317) 841-7029
Email: mwitkowski@totsindy.com

Note: Signature for acceptance of this policy will be made on the general consent form

Financial Agreement

In order to obtain reimbursement for services provided to my child by Theracare Outpatient Therapy Services (TOTS), I authorize disclosure of my child's record for treatment, payment, and healthcare operations.

If the therapy services provider is a participating provider in my insurance plan, I hereby assign medical benefits due be paid directly to Theracare Outpatient Therapy Services.

I understand that I am financially responsible for any balances not paid by my insurance carrier within 60 days from the date of services. If the patient fails to provide proof of insurance within 60 days, the patient is responsible for the balance in full. If no Secondary Insurance information is provided, I attest and affirm that I have no other insurance other than that listed as Primary Insurance. Patient with no insurance coverage are considered self pay patients.

I understand that if my child's account becomes delinquent it will be assigned to an attorney for collection and/or suit, and the prevailing party shall be entitled to reasonable attorney's fees and cost of collection and my family will be asked to seek medical care elsewhere.

This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

Note: Signature for acceptance of this policy will be made on the general consent form

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****PLEASE READ AND INITIAL EACH SECTION AND SIGN AT THE BOTTOM****

Child's Name: _____ DOB: _____

CONSENT FOR MEDICAL TREATMENT OF A MINOR

I (we) the undersigned legal parent(s) or guardian(s) of stated child, a minor, do hereby authorize and consent to any treatment rendered under the general or special supervision of any Theracare Outpatient Therapy Services Therapist or Assistant, a duly licensed therapist or assistant, licensed under the provisions of the laws in the State of Indiana. It is understood that this authorization is given in advance of any specific diagnosis, recommended treatment, or recommended medical care being required but is given to provide authority and power to render care, which the aforementioned therapist or assistant in the exercise of his or her best judgment may deem advisable.

Restrictions to Treatment: _____

_____**Initials**

FINANCIAL RESPONSIBILITY AGREEMENT

I have received, read, and agree to adhere to the Theracare Outpatient Therapy Services' Financial Responsibility Agreement.

_____ **Initials**

NOTICE OF PRIVACY PRACTICE

I have received and read the Theracare Outpatient Therapy Services' Notice of Privacy Practice

_____ **Initials**

CONSENT FOR COMMUNICATION VIA ELECTRONIC MAIL

I have read and agree to the Theracare Outpatient Therapy Services consent for communication via electronic mail. Email communication is initiated by parent to Director of Outpatient Therapy Services.

_____ **Initials**

Email address _____

Legal Parent/Legal Guardian Signature: _____

Printed Name: _____

Relationship to Child: _____ **Today's Date:** _____