P.A.T. Kids
Pediatric Advanced Therapy

Checklist for Occupational Therapy

___ Completed Intake Paperwork

___ Previous OT/PT Information

___ Allergy Notification

___ Current school patient attends _____

___ Current copy of IEP for patients 3 years and older

___ Check here if patient does not have an IEP

___ Copy of Insurance/Medicaid Card

P.A.T. Kids
Pediatric Advanced Therapy

_____ is scheduled for

a(n) ____OT/PT/Speech Evaluation__on_____

at _____ with _____.

DIRECTIONS TO OUR CLINICS

Please print, complete fully, and bring this new patient packet with you to the evaluation.
Please bring your child's insurance and/or Medicaid card with you.
Please bring a copy of your child's IEP, if applicable.
*****Please bring any past evaluations your child may have.*****

PLEASE FOLLOW THE DIRECTIONS BELOW! (MapQuest and GPS are not always accurate in locating our offices!)

MOORESVILLE, NC LOCATION

From Charlotte: Take I-77 North to exit 36. At top of ramp, turn right onto Hwy. 150 East.
From Statesville: Take I-77 South to exit 36. At top of ramp, turn left onto Hwy. 150 East.

You will go past the Walmart on the right, and Belk and Kohl's on the left.
At next traffic light, turn left onto Corporate Center Dr. (by Zaxby's).
At stop sign, go straight onto Upper Crest into Talbert Pointe Business Park.
At stop sign turn left onto Overhill Drive (by AcroFitness).
Turn right onto Infield Court. We are located at the bottom of the cul de sac
134 Infield Court Mooresville, NC 28117

CHARLOTTE, NC LOCATION

2520 Whitehall Park Drive Suite 350
Charlotte, NC 28273

SALISBURY, NC LOCATION

Our office is adjoined to/in the same building as Salisbury Pediatrics.
129 Woodson Street Salisbury, NC 28144
**Please see the next page for more details about this location.

IMPORTANT: ALL PAPERWORK MUST BE COMPLETED BEFORE YOUR CHILD'S EVALUATION!

704-799-6824 Fax: 704-799-6825 www.pediatricadvancedtherapy.com

SALISBURY LOCATION DETAILS

Please enter through the
main lobby door
at Salisbury Pediatrics and wait
in the far left lobby (near the pharmacy) for your therapist to come out and greet you.
You do not need to check in with the Salisbury Pediatrics staff.

****Please do not enter through the side door as treatment may be in session.**

INSURANCE PAYMENT ESTIMATES:

The benefits quoted to us by your insurance are as follows*:

You are financially responsible for:

☐ $_____ Individual Deductible

☐ $_____Family Deductible

****The evaluation will cost approximately $_____. If you have NOT yet met your deductible (either individual or family), treatment sessions will approximately be $_____ until the deductible is met. Once met, each visit should be about $_____ per session.****

Self-pay rates (if not filing to insurance): $95.00 for evaluation and $80.00 per treatment session.

☐ $ _____ Co-pay

☐ _____ % Co-insurance

☐ $0 due because your child has Medicaid

☐ Your plan is limited to ___visits per _____year_____.

☐ No visit limit.

Other:

_____

_____

_____

Payment is expected at the time of service.

We accept cash, check, discover, visa or mastercard.

Notice of Privacy Practices is on the back side of this sheet for your records.

** This information was given to us by your insurance company. You should also call your insurance company to verify your benefits. Discrepancies should be taken up with your insurance company, not PAT. These are just estimates and until we receive the Explanation of Benefits from your insurance company, we are unable to predict exact payments.*

IMPORTANT: ALL PAPERWORK MUST BE COMPLETED BEFORE YOUR CHILD'S EVALUATION!

Dear Parent(s) or Guardian(s),

Pediatric Advanced Therapy is committed to providing you and your family with the best possible care. Please understand that our office policies are in place to ensure that we are able to continue to provide excellent care to all of our patients. Your understanding of these policies is a vital piece to your child's progress in treatment, and we invite you to ask if you have any questions at any time.

As a courtesy for our patients' families, we will call your insurance carrier before treatment begins to verify coverage and benefits. The information we obtain is not a guarantee of payment; your insurance will process the claims based on your specific policy, medical necessity, and any exclusions or limitations attached to your plan. It is important that you understand that you will be responsible for any charges not covered by your insurance plan including—but not limited to—deductible, co-insurance, and co-payments. In addition, many insurance plans have a maximum number of therapy visits covered per year, with anything in addition being the responsibility of the patient. We do have a reduced, self-pay rate that we will apply if/when this occurs.

I have read and understand the financial policy for Pediatric Advanced Therapy, and agree to be responsible for any charges accrued on my account. I agree to keep my account current by either paying at the time of service or within 30 days of invoice. I understand that a member of the office staff will always be available to answer any questions I may have regarding my account.

Attached you will find the information we received from your insurance company, with a quote of expected benefits and patient out-of-pocket portions.

Printed Name Signature Date

Automatic Debit and Credit Authorization Form

This form is to allow Pediatric Advanced Therapy to withdraw funds from your designated Credit Card or Debit Card to make your monthly account payments.

I hereby authorize Pediatric Advanced therapy to charge my credit/debit card indicated below on the day of each month (as indicated on my installment contract). I understand that if my card is declined Pediatric Advanced Therapy will continue to run the authorized payment request daily until funds are available and the payment has been posted to my account.

This authority is to remain in full force and effect until Pediatric Advanced Therapy has received notification from me (or either of us) of its termination or until my account balance has reached zero.

My first payment of $_____ will be debited on_____ and every payment thereafter will be debited on the _____day of the month (if applicable).

My payments will be debited: **Monthly** **Weekly** **Per Session** **Other:**

My payments will not exceed: $_____

Credit Card: **Visa** **MasterCard** **Other**

Name on Card:_____

Card Number:___ ___ ___ ___-___ ___ ___ ___-___ ___ ___ ___-___ ___ ___ ___

Expiration Date: _ _/_ _ Security Code: _____

Address:_____

City:_____ State:_____ Zip:_____

Patient Name:_____

Parent/Guardian Name:_____

Signature_____

Date:_____

Has your child received services anywhere else? Y or N
If yes…

When:_____
Where:_____
Which therapy:_____
Discharged: (Y or N)
Date of discharge:_____

Is the child receiving services right now (including school)? (Y or N)
If yes…

Where:_____
Name of therapist:_____
Which therapy:_____
How many times a week:_____
If school, what day of the week:_____

Do you authorize Pediatric Advanced Therapy to contact other providers? (Y or N)
If yes, please sign the consent form attached.

CONSENT FOR THE RELEASE & EXCHANGE OF INFORMATION

I give permission for the exchange of information (verbal and/or written) regarding my child,

_____,
(Child's Name)

to be shared between Pediatric Advanced Therapy and

_____
(Name/Position)

_____
(Agency/School)

_____
(Address/Phone)

I understand that unless otherwise indicated, this information will be used only for treatment or educational purposes such as assessments, curriculum programming and coordination of services. I also understand that the agency receiving this information will be responsible for the confidentiality of this information.

_____
(Parent)

_____
(Date)

IMPORTANT!

Please arrive 15 minutes **before** your scheduled appointment.

ALL paperwork must be completed prior to your appointment and turned in at the window upon arrival.

What to Expect During the Evaluation

- Please arrive 15 minutes before your scheduled appointment with all of your paperwork completed.
- Our front office staff will discuss your insurance with you upon arrival if it has not already been discussed over the phone.
- Your evaluating therapist will review your paperwork and come greet you in the lobby.

During the evaluation:

- Parents are welcomed to come back into the treatment rooms during the evaluation to speak with the evaluating therapist.
- Please share your concerns for your child, medical and developmental history as well as challenges that occur within your daily routine. It is helpful to know how they do in a variety of settings as well, not just at home with you, i.e. school, play dates etc.
- Please share any precautions or limitations your child may have with regard to physical movement, environmental or food allergies.
- The evaluating therapist will complete structured and unstructured clinical observations of your child's movement patterns, sensory processing and age appropriate skills.
- The evaluating therapist will most often provide questionnaires for you to complete during your time and at this point may ask you to fill these out in the lobby while they complete additional standardized testing in a small room at a table (where appropriate). Parents are always welcome to stay for the duration if they prefer and with younger children and infants, that is typical.
- At the end of the evaluation, your therapist will share with you deficits that have been noted and decide whether or not your child requires skilled therapy intervention.
- If therapy is required, it is best to discuss days and times with the office staff before you leave so that they can begin working to find you an appointment time.
- Before you leave, you will receive educational handouts about what to expect from treatment as well as basic information regarding your child's specific difficulties.
- Your therapist will compile test scores and a written report with treatment goals.
- You can expect a report to be mailed to you within 2 weeks or sometimes it will be given to you at your next appointment.

If you have any questions, please feel free to call and ask prior to your appointment, or you can ask the evaluating therapist or office staff upon arrival. We look forward to working with you and your child to help them reach their full potential!

Sincerely,
The PAT Staff

Date: _____

NEW CLIENT INFORMATION

Referred by: _____

Welcome to Pediatric Advanced Therapy (formerly Integrative Therapy Concepts)

We look forward to working with your child. Please provide us with the following information:

Client's Name: _____ _____ _____

First M Last

Client prefers to be called: _____ Date of birth: _____/_____/_____

Parents' names(s): _____

Home phone: _____ Cell phone: _____ Work phone: _____

Email address: _____

Home address: (if using a PO Box, you must also list a physical address) _____

City: _____ State: _____ Zip Code: _____

Patient's School Name & Current Grade: _____

Emergency contact: _____ Phone#: _____

Relationship to client: _____

Pediatric Physician & Practice: _____Phone#: _____

ACKNOWLEDGEMENT and ASSUMPTION of RISK

I acknowledge and agree to have my child (or the child under my care), receive occupational therapy services from Pediatric Advanced Therapy. I acknowledge that there is some risk inherent in the use of the therapy equipment and I agree to assume such risk and indemnify and hold Pediatric Advanced Therapy and its staff, harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child or our belonging.

MEDICAL TREATMENT RELEASE:

In the event of an emergency situation at Pediatric Advanced Therapy, I give the staff of PAT my permission to initiate emergency medical services for the child listed above if I am not present during the emergency. My hospital preference is _____, however I acknowledge that Pediatric Advanced Therapy will not be held responsible for hospital or EMS providers designated.

Please note: If your child has any of the following conditions it is <u>mandatory</u> that you remain on the premises during his or her therapy session. These conditions include: Seizures, severe allergies, significant behavioral issues, and any condition that requires medicine to be controlled. This is for the safety of your child and the protection of our staff.

(1) PRIMARY INSURANCE COMPANY: _____ Phone #: _____

ID# _____ Group # : _____

Policy Holder: _____ Date of birth: _____/_____/_____ Employer: _____

(2) SECONDARY INSURANCE COMPANY: _____ Phone #: _____

ID# _____ Group # : _____

Policy Holder: _____ Date of birth: _____/_____/_____ Employer: _____

ASSIGNMENT OF INSURANCE TO PEDIATRIC ADVANCED THERAPY:

I authorize direct payment of medical benefits to Pediatric Advanced Therapy. The benefits referred to herein would be payable to me (policy holder) if I did not make assignment and include Major Medical Insurance. **I understand that I am personally responsible to Pediatric Advanced Therapy for any and all payments not covered by the insurance companies, such as co-payments, co-insurance, deductibles and denied services. All payments are due at the time of service.**

The attending therapist is authorized to release any medical information required in the administering of applications for financial coverage for service required. He/she may also send the results of the evaluation and recommendations to my referring physician for coordination and continuity of care. I have carefully completed this form and to the best of my knowledge it does not contain any false, incomplete or misleading information.

Signature: _____ Date: _____

PLEASE COMPLETE THE BACK SIDE/NEXT PAGE!

POLICIES & PROCEDURES *Revised 2/4/2015*

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the services you receive at Pediatric Advanced Therapy. We are required by law to inform you of the "class of persons" who will have access to your medical information in order to carry out their job duties. This would include our therapy staff, administrative & billing staff and management. We may use and disclose your medical information for the purpose of treatment, payment and health care operation activities.

All evaluations usually last for one hour. It is the responsibility of the parent/guardian to bring all pertinent information to the evaluation. This includes your completed paperwork, insurance card, Medicaid card, and any medical history and/or past evaluations your child has received. You will need to be present for the first 20 minutes of the evaluation so that the therapist can ask you some questions. The remainder of the evaluation time will include clinical observation and in most cases, standardized testing. For liability reasons, we can only allow the children who are being treated into the gym and therapy rooms. **Siblings MUST stay in the lobby, NO EXCEPTIONS.**

Occupational and Physical Therapy sessions last for 50 minutes. Following the session is a 10 minute window to discuss your child's therapy with the therapist. It is mandatory that you are in the lobby during this 10 minute time frame. Please have your child use the restroom prior to the treatment session. Speech Therapy evaluations last for one hour and treatment sessions are 30 minutes.

If you leave the clinic while your child is in session, you **MUST** leave a phone number where you can be reached. You must return to the clinic before your child's session ends. This allows time for the therapist to speak with you regarding your child's treatment and progress, and also keeps the next client's session on schedule. **Please note: If your child has any of the following conditions it is <u>mandatory</u> that you remain on the premises during his or her therapy session. These conditions include: Seizures, severe allergies, significant behavioral issues, and any condition that requires medicine to be controlled. This is for the safety of your child and the protection of our staff.** If you arrive late for your session, your appointment will still end at the original end time.

Please try to give 24 hour notice when cancelling an appointment. (Occasional last minute emergencies are understood.) If you call after hours, please leave a message on our answering machine. Frequently cancelled appointments (3 within a 6 week period) will be basis for removal from our permanent schedule. When we establish a treatment plan for your child, we base our goals on the child having consistency. If your child misses appointments, they will not meet their goals as quickly, and your child will have to be enrolled in therapy for a longer period of time. The success of our treatment sessions depends on consistency. Medicaid and insurance companies require us to report attendance and show progress towards goals. In the event that you do have to cancel, we strongly encourage you to schedule a make-up appointment, even if it is with another therapist. It is often beneficial for your child when another therapist treats him or her because it gives the regular attending therapist another opinion or ideas for your child. Our staff is always in close communication with each other.

In the event that the therapist needs to cancel, we will reschedule your child with another therapist for continuity of treatment.

Failure to cancel or to appear for an appointment is considered a "NO SHOW." We will charge a $25.00 fee for "NO SHOW" appointments. After 3 "NO SHOW" appointments or late cancellations your appointment spot will be terminated. Please see our attached cancellation policy for further details.

At Pediatric Advanced Therapy, we will file with your insurance company as a courtesy. It is important for you to understand that when we contact your insurance company to verify benefits, they are only providing us with a quote. You should also call your insurance company to verify your benefits and check your benefits in your plan booklet. Many insurance plans have a limited number of visits for outpatient therapies. It is your responsibility to keep track of the number of visits your child has used. **Verification of coverage is NOT a guarantee of payment. Benefits and payment will be determined by your insurance company once the claims are received.** Any payments not covered by insurance or Medicaid will be the sole responsibility of the parent/guardian.
<u>All payments are due at the time of service.</u> We are required under contractual agreements with insurance companies to collect co-payments at the time of service. If you have a deductible that has not been met you should be prepared to pay the full allowable amount at each visit until your deductible is met. (*For example, if you have a $500 deductible, this means that your insurance company will not pay any money towards your medical expenses until YOU, the member, have spent $500 of your own money towards medical expenses.)*

- ⇨ ***I understand that I MUST return 10 minutes before my child's session ends.*** _____ (please initial here)
- ⇨ ***I understand that I will be billed for "NO SHOW" and late cancellation appointments.*** _____ (please initial here)
- ⇨ ***I agree to the payment terms listed above.*** _____ (please initial here)

I have read the Policies & Procedures listed above and have received a Notice of Privacy Practices from Pediatric Advanced Therapy.

Signature of parent/guardian: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

PURPOSE: This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. **Please read carefully.**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the services you receive at Pediatric Advanced Therapy. We need this record to provide you with quality care and to comply with certain legal requirements. We are required by law to maintain the privacy of protected health information. This notice will tell you about the ways we may use and share medical information about you.

USE AND DISCLOSURE OF MEDICAL INFORMATION: Following is a list of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written information you provide may be revoked at any time by writing to us.

- **FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you. We may discuss medical information about your child with interdisciplinary staff at Pediatric Advanced Therapy to improve their overall care.
- **FOR PAYMENT:** We may use and disclose your medical information for payment purposes.
- **FOR HEALTH CARE OPERATIONS:** We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting the accreditation, certificates, licenses and credentials we need to serve you.
- **ADDITIONAL USES AND DISCLOSURES:** In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Court orders and Judicial and Administrative proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purpose of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health and safety of others. We may also share medical information when necessary to help law enforcement officials capture a person who admitted to being a part of a crime or has escaped from legal custody.

Health Oversight Committees: We may disclose medical information to an agency providing health over sight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

YOUR INDIVIDUAL RIGHTS: ***You have a right to:***

- Look at or receive copies of your medical information.
- 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 expectations.
- Receive your own confidential health information by alternative means or alternative locations.
- 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).
- Request that we change 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 an explanation. You may respond with a statement of disagreement that will be added to the information you want 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 any changes in any future sharing of that information.

In each case, you must make your request in writing to the Privacy Officer at Pediatric Advanced Therapy.

QUESTIONS AND COMPLAINTS: If you have any questions about this notice or if you think that we have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. This complaint must be filed within 180 days of when the complainant knew or should have known that the act had occurred. The secretary may waive this 180 day time limit if good cause is shown.

This notice is effective April 14, 2003.

I have received and understand the Privacy Practices of Pediatric Advanced Therapy.

Child's Name: _____ Parent/Guardian Signature: _____ Date: _____

Pediatric Advanced Therapy will be collecting video and photograph records of your child's performance during therapy sessions for their electronic medical record. I understand and consent, as this will benefit their therapy program.

Signature of Parent/Guardian: _____

Date: _____

Additional Options

I consent for photographs/videos to be used in office for staff wide trainings: Y/N

Signature: _____

I consent for photographs/videos to be used for research: Y/N

Signature: _____

I consent for photographs/videos to be used for media purposes (i.e. marketing/website): Y/N

Signature: _____

BACKGROUND INFORMATION and OCCUPATIONAL HISTORY

(This form is intended to be completed by the child's parents or primary caregivers)

FAMILY INFORMATION

Child's Name: _____ Today's Date: _____

Birth date:_____Age: years months Home Phone: _____
Address:_____
City: _____Zip:_____
County:_____Email Address: _____
Mother's Name:_____Age: Occupation: _____
Office/Cell Phone: _____
Father's Name:_____Age:_____Occupation:_____
Office/Cell Phone: _____
Other: Caregivers/Foster parents:_____Cell Phone: _____
Child resides with: _____

REFERRING INFROMATION

Who **referred** this child for an evaluation? _____
Reason for referral: _____
_____
When did you first have those **concerns**? _____
_____
What do you see as your child's **strengths**? _____
_____
_____
In one sentence, how would you **describe your child**? _____
_____
_____
List all **concerns** that you may have: _____
_____
_____
List concerns that arise out of your child's daily routine: (Including morning routine, school, eating, sleeping, dressing) _____
_____
What are our primary **goals** regarding therapy? _____
_____
_____
Did your child receive Occupational Therapy services in the past: (Yes/No) _____
At what age?_____ Duration: _____

SCHOOL HISTORY

Hand preference:_____Current school placement: _____
Present grade:_____Have any grades been repeated? _____
Is your child in the EC program or receiving any support services? (specify) _____
_____
What does the teacher say about your child? _____
_____
Does your child receive any therapy at school? (i.e. Speech Therapy, Occupational Therapy, PhysicalTherapy)

MEDICAL HISTORY

Any difficulties or illnesses during pregnancy? (specify) _____

_____

Length of pregnancy: _____

Birth was: Normal [ ] Caesarian [ ] Breech [ ] Twins or more [ ]

Birth weight:_____Did baby require assistance in starting to breathe? Yes [ ] No [ ]

Remarks:_____

Were there any complications/problems in early infancy? Yes [ ] No [ ] (please specify)

_____

_____

Were there any feeding difficulties in early infancy? Yes [ ] No [ ] (please specify)

_____

_____

Does your child have a diagnosis? _____

Diagnosed by whom?_____Date:_____

Does your child have now or in the past had significant health problems?

Surgery? Explain_____Hospitalization? Explain _____

_____

_____

Respiratory, Lung, or Bronchial difficulties?_____Cardiac Problems? _____

Seizures? (when and how often)_____

Allergies?_____

Emergency plans? (i.e. Epipen) _____

Ear Infections? _____

Is your child currently on any medications? Yes [ ] No [ ]

If yes, please give a list and state reasons) _____

_____

Previously tried medications: _____

Physical limitations/precautions to be aware of: _____

Does your child use any specialized equipment? (Explain) _____

_____

INTERVENTION HISTORY

Has your child had a hearing evaluation? Yes [ ] No [ ]

By whom:_____Date:_____

Has your child had a vision evaluation? Yes [ ] No [ ]

By whom:_____Date:_____

Has your child had a psychological evaluation? Yes [ ] No [ ]

By whom:_____Date:_____

Has your child had a neurological evaluation? Yes [ ] No [ ]

By whom:_____Date: _____

Others (please specify) _____

_____

DEVELOPMENTAL HISTORY

Children sometimes act or appear younger than there chronological age. What age do you think best describes your child and why? _____

_____

Developmental Milestones:

Sitting:_____months Crawling:_____months Walking:_____months

Babbling:_____months 1st word:_____months Combining words:_____months

Self-Help: (Circle yes/no)

Dressing		**Grooming**		
Put on shirt independently	Y/N	Bathing independently		Y/N
Button independently	Y/N	Combing hair		Y/N
Zips independently	Y/N	Toilet trained	Bowel	Y/N
Ties shoes	Y/N		Bladder	Y/N
Snaps independently	Y/N	Toileting independently		Y/N
Dress self independently	Y/N			

Hand Function

Reaching for objects	Y/N
Finger Feeding	Y/N
Using Knife for cutting	Y/N
Eating with spoon	Y/N
Drawing a circle	Y/N
Cutting with scissors	Y/N

Does your child have difficulty learning new motor skills? _____

_____

How does your child communicate?_____

Daily Routines:

How well does your child do the following? (Circle yes/no) Explain if needed.

Sleeping: *Wake up during the night: yes/no*_____

Difficulty falling asleep: yes/no _____

Does your child have a difficult time to wake up in the morning: yes/no _____

Sleep in own bed: yes/no _____

Take naps during the day: yes/no _____

Describe your child's bedtime routine: _____

_____

Eating: *Picky eater: yes/no*

Avoid certain textures: yes/no

Gags at/on foods or utensils: yes/no

Avoids food that requires lots of chew: yes/no

Explain: _____

Toileting: *Independent with toileting: yes/no*

Following toilet training routine: yes/no

Explain: _____

Playing: *Difficulty playing alone: yes/no*

Duration of play: 1-2 min____5-10 min_____more ____

Difficulty with pretend play: yes/no
Difficulty using playground equipment: yes/no
Does your child avoid certain types of toys (i.e. textured toys): yes/no
Does your child avoid any messy play (i.e. sand, paint, glue, etc): yes/no
Difficulty playing with other children: yes/no Explain: _____
Explain: _____
_____

Behavior:

Does your child exhibit tantrums: yes/no Frequency:____times/day or____times/week
What triggers the tantrums? _____
_____
Duration of tantrum: _____
What strategies do you use to calm your child during a tantrum? _____
_____
What do you do that works the best to obtain cooperation from your child? _____
_____

Family Impact Questionnaire

Name of Child receiving services_____Age:_____
Diagnosis (if applicable)_____Date: _____
Number of years child has received therapy services:_____Overall: _____
Programs in which your child has participated (circle all that apply):
OT PT Speech Early Intervention Special Education Other: _____
Person completing the questionnaire: _____
Relationship to child: mother father other (specify) _____

Please answer the following questions in relation to how things are going for your child and family now. Think about the last month or so (rather than the entire last year or just the last day or two). If your child has been sick, or has experienced some unusual event (i.e. the loss of a long time caregiver) try to answer the questions in terms of how things were going just before the event.

1. Does your child:

	ALWAYS	OFTEN	SOMETIMES	RARELY	NEVER	NOT APPLICABLE
a. play with friends?						
b. make and keep friends?						
c. relate to being part of the family?						
d. interact and play with siblings?						
e. interact with parents and significant adults?						
f. communicate needs, wants, and interests effectively?						
g. “fit in” with peers?						

2. How often do the following daily household routines run smoothly for your child and family?

	ALWAYS	OFTEN	SOMETIMES	RARELY	NEVER	NOT APPLICABLE
a. getting ready to go somewhere						
b. leaving the house in the morning						
c. meal preparation and cleanup						
d. mealtimes						
e. getting ready for and going to bed						
f. bathing and grooming activities						

3. How often do the following experiences go smoothly for your child and family?

	ALWAYS	OFTEN	SOMETIMES	RARELY	NEVER	NOT APPLICABLE
a. running errands						
b. leaving to go out on overnight trips						
c. shopping trips for groceries or clothes						
d. dining out						
e. birthday parties						
f. recreational activities such as bike riding or ball games						
g. family outings such as going to the park, museum, or the movies						
h. family						

gatherings (i.e. holidays, weddings, birthdays, etc)						
i. vacations						
j. spontaneous outings						
k. following through with plans (i.e. not having to cancel at the last minute)						
l. taking your child with you rather than leaving him or her at home						

4. Considering your child's special needs, is your family able to:

	ALWAYS	OFTEN	SOMETIMES	RARELY	NEVER	NOT APPLICABLE
a. find and keep a babysitter?						
b. socialize with extended family?						
c. socialize with friends?						
d. stay involved with the community?						
e. participate in the neighborhood?						

Comments: (Please include any areas that you think are significant for your family.)

_____

_____

_____

Describe a typical day for your child from waking till bedtime including whether it is different from your child to get to sleep at night and stay asleep. _____

_____

_____

_____

_____

Child's Name: _____

Today's date: _____

Form completed by: _____

Relationship to child: _____

SENSORY PROCESSING SCREENING CHECKLIST

This checklist was designed to be a quick screening tool for sensory processing deficits. Please indicate if your child always responds or greater than 50% of the time responds. If several items are checked throughout many categories or most items are checked in one category, sensory processing deficits may be present.

Tactile Processing (sense of touch)

☐ bothered by clothing tags/textures
☐ refuses to wear shoes/socks
☐ avoids messy play (glue,paint)
☐ refuses to play in sand at beach
☐ hates haircuts, nail trim, tooth brush
☐ reacts neg. to touch/pulls away
☐ unaware of pain or temp.
☐ prefers to touch vs be touched
☐ withdraws from splashing water
☐ revs up after bath
☐ rubs/scratches where touched
☐ mouths clothing/objects
☐ overly fidgets/tugs at clothing
☐ does not like hands dirty

Auditory Processing (hearing)

☐ covers ears at loud noises
☐ upset with vacuum, hairdryer,toilet
☐ difficulty following directions
☐ appears to ignore name called
☐ unaware speaks too loudly
☐ distracted by background noises
☐ notices noises usually tuned out
☐ difficulty eating in noisy places
☐ slow to respond to verbal cues
☐ escapes from noisy places

Visual Processing (vision)

☐ poor eye contact
☐ likes to stare at shiny/spinning things
☐ prefers dark/ avoids bright sunlight
☐ turns whole body to look at you
☐ squints/covers eyes in sunlight
☐ covers/closes one eye when writing
☐ prefers fast paced tv shows
☐ misinterprets facial expressions
☐ illegible writing
☐ difficulty copying from the board

ADL/Play skills

☐ difficulty completing grooming or dressing in reasonable time/skill
☐ difficulty using eating utensils
☐ unable to manage clothing fasteners

☐ difficulty following or copying gestures
☐ does not prefer or play with age appropriate toys

Proprioception (position sense)

☐ overly rough in play
☐ seems to enjoy crashing
☐ jumps from unsafe hts./jumps a lot
☐ holds pencil too hard
☐ appears clumsy/ poor coordination
☐ moves stiffly
☐ slouches at desk or table
☐ fatigues quickly
☐ prefers sedentary play
☐bumps into others/pushes others
☐ uses too much force to throw or kick

Vestibular (movement sense)

☐ on the go/trouble sitting still at table
☐ twirls self during the day; fidgets
☐ does not appear to get dizzy
☐ afraid of heights
☐ seeks out swinging or climbing more than typical
☐ poor safety awareness/ use of caution
☐ avoids movement on playground
☐ fearful with head tipped back during bath or diaper change
☐ afraid of elevators or escalators
☐ leans on others for support when sitting or standing
☐ moves slowly on uneven surfaces
☐ loses balance easily
☐ becomes overly excited w/movement

Oral Processing (taste)

☐ picky eater (refuses food due to temp or texture)
☐ gags at/on foods or utensils
☐ hates tooth brushing
☐ bites/chews on nonfood items
☐ avoids foods that require lots of chew
☐ craves certain foods/textures

Olfactory (sense of smell)

☐ smells everything
☐ bothered by smells other do not notice
☐ refuses food based on smell

Behavior

☐ difficulty with transitions/ changes in routine
☐ poor frustration tolerance
☐ impulsive; poor self control
☐ overly emotional or sensitive
☐ frequent tantrums/meltdowns
☐ unable to calm self after tantrum
☐ difficulty sleeping thru the night
☐ difficulty getting started with tasks

Social Skills

☐ difficulty making or maintaining friendships
☐ unable to interpret social cues
☐ does not understand age appropriate jokes
☐ unable to sympathize with others
☐ easily upset by criticism
☐ tries to control others/bossy
☐ does not share easily/take turns
☐ does not respect personal space of others

Cancellation Policy

Effective March 2,2018

Pediatric Advanced Therapy aims to provide the highest quality of care to all patients. In the interest of all of our patients, we are implementing a 24 hour cancellation policy effective January 1, 2017. All cancellations require 24 hours notice to avoid a cancellation fee. By implementing this policy, we will have the ability to replace cancelled appointments with patients in need and provide the best care for our collective patients.

Our policy is as follows:

1. Patients that cancel with more than 24 hours notice will not be subject to a cancellation fee. If a patient cancels more than 3 times in a 10 week period, they are subject to being removed from the permanent schedule.
2. Any patient that no shows for an appointment without a prior call will immediately be subject to a $25 no show fee.
3. Any patient cancelling with less than 24 hours' notice will be subject to a $25 cancellation fee.
   *If a patient schedules and attends a make-up session within the week of (or the week following) the cancellation, the cancellation fee may be waived.
4. If you cancel 2 weeks in a row due to sickness, we require a doctor note in order to attend next session.

If you have questions or would like to discuss your scheduling needs, please call 704-799-6824.