

Therapeutic Potentials, Inc.
Patient Information

PATIENT: _____ BIRTHDATE: _____ AGE: _____

GENDER: MALE FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

GUARDIAN#1: _____ RELATIONSHIP: _____

SOCIAL SECURITY #: NA BIRTHDATE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

GUARDIAN#2: _____ RELATIONSHIP: _____

SOCIAL SECURITY #: NA BIRTHDATE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

EMERGENCY CONTACT PERSON: _____

HOME PHONE: _____ CELL PHONE: _____

PHYSICIAN: _____ FACILITY: _____

ADDRESS: _____

PHONE: _____ FAX: _____

REFERRAL SOURCE: _____

INSURANCE INFORMATION

PRIMARY INSURED: _____ DOB: _____

INSURANCE COMPANY: _____ PH#: _____

ID NUMBER: _____ GROUP#: _____

EMPLOYER: _____

Please Attach a Copy of Insurance Card Front and Back

Consent to Treatment Form

Patient Name: _____ **DOB:** _____

CONSENT TO MEDICAL TREATMENT:

I, the undersigned, whether acting as parent, guardian, responsible party, or agent, voluntarily consent to therapy as determined to be necessary or beneficial in the professional judgment of my physician or therapist that falls within the scope of practice as defined by the State of Florida.

I acknowledge that no guarantees have been made to me as to the effect of such treatment on the patient's condition.

By signing this form, I acknowledge that I have read and understand the contents and that I am authorized to execute it on behalf of the patient.

Name (Client, parent, guardian, responsible party) <i>Please print</i>	Relationship
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Signature (Client, parent, guardian, responsible party)	Date
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Financial & Office Policy

Patient Name: _____ **DOB:** _____

This Financial Policy will explain our billing policy and expectations. Please read it carefully. A copy will be provided upon request and a copy is kept with your billing and medical records.

Payment is expected at the time services are rendered. I understand that I am responsible for all deductibles, coinsurance, co-payments and/or non-covered services. A claim for services will be filed to the insurance company as a courtesy, however, all follow-up of unpaid claims will be my responsibility.

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

Balances remaining unpaid over 30 days may accrue interest in the amount of 1.5% of my balance each month (18% APR) and may be turned over to an outside agency for collection. The undersigned agree(s) that in the event of default or that the account is placed with a collection agency for collection, I am responsible for reasonable attorney's fees, collection agency fees, court costs, service charges, and/or interest as allowed by the law. In the case that legal action is instituted to collect such fees due to failure to pay on my part, I agree to pay in addition to the costs and disbursements provided by statute such sum as the court may adjudge reasonable as attorney's fees in said action. In a divorce situation, as a parent, I am responsible for all charges incurred. Although a divorce decree may state that an ex-spouse is responsible for medical bills, Therapeutic Potentials, Inc. has no authority to enforce compliance with such a decree and requires payment in accordance with this policy. You may report information about my account to credit bureaus. Late payments, missed payments, or other defaults on my account may be reflected in my credit report.

Therapeutic Potentials, Inc., reserves the right to discontinue all therapy services until delinquent accounts are satisfied.

Brief conferences as well as brief telephone conferences are considered part of the regular intervention program, and no additional charges will be made. There will be a charge for conferences with parents, physicians, tutors, or teachers that exceed 10 minutes in length.

If I must cancel a scheduled appointment, it is necessary that I give 24 hour advance notice. Except in the case of emergency or sudden illness, and except for Medicaid clients, appointments that are not cancelled with a 24 hour advance notice will be charged as if session was held. Medicaid patients who miss three scheduled appointments without a 24 hour advance notice (except in cases of emergency or sudden illness) will become ineligible to receive further services from Therapeutic Potentials, Inc. At various times of the year, my child's therapist may be away from the office. I will be notified in advance of the dates and a makeup session will be scheduled or a substitute therapist will be offered.

Returned check policy: A \$50.00 fee will be charged to your account for all returned checks.

I have read and accept the above policies and authorize Therapeutic Potentials, Inc., to provide evaluation and therapeutic services for my child.

Name (Client, parent, guardian, responsible party) *Please print*

Relationship

Signature (Client, parent, guardian, responsible party)

Date

Illness Policy

Patient Name: _____ **DOB:** _____

An illness policy is important in order to reduce the spread of illness within our clinic. We want to provide consistent services to the patient, however, if they are ill please keep them at home for 24 hours after the symptoms have disappeared.

Please do not attend therapy if the following symptoms occurred during the past 24 hours:

- FEVER
- VOMITING
- DIARRHEA
- CONSTANT RUNNY NOSE (allergies not included)
- HEAD LICE
- RASH (if you have a doctor's note indicating that the rash is not contagious, you may attend therapy)

I have read and accept this policy.

Name (Client, parent, guardian, responsible party) *Please print*

Relationship

Signature (Client, parent, guardian, responsible party)

Date

Release of Personal Health Information

Patient Name: _____ **DOB:** _____

I, _____, authorize Therapeutic Potentials, Inc. to Release Personal Health information to the following professionals:

Please print names and phone numbers:

Educators _____

Caregivers _____

Physicians _____

Speech Language Pathologist _____

Occupational Therapist _____

Physical Therapist _____

Psychologists _____

Other _____

Other _____

Other _____

Name (Client, parent, guardian, responsible party) <i>Please print</i>	Relationship
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Signature (Client, parent, guardian, responsible party)	Date
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Therapeutic Potentials Inc.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at anytime. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights Section of the notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved With Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up therapeutic tools or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health 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 disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1.00 for each page for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request your made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may 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 upon request.

We support your right to the privacy of you health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Ray Colombo

Telephone: 941-758-3140

Fax: 941-870-4891

E-mail: RColombo@TPIKids.com

Address: 6977 Professional Parkway East Sarasota, FL 34240

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ **DOB:** _____

*You May Refuse to Sign This Acknowledgement

I _____ have received a copy of this office’s notice of Privacy Practices.

I authorize Therapeutic Potentials, Inc., to share Protected Health Information with the following person(s):

_____ Relationship _____

_____ Relationship _____

May we leave appointment information on your answering machine? YES NO

May we leave medical or billing information on your answering machine? YES NO

May we text appointment information to your cell phone? YES NO

May we email you appointment or billing information? YES NO

Name (Client, parent, guardian, responsible party) *Please print* **Relationship**

Signature (Client, parent, guardian, responsible party) **Date**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement (Specify)

Staff Signature

Date

Patient History

NATURE OF PROBLEM

Describe your child's speech, language, fine motor, gross motor and/or learning difficulties.

When was it first noticed?

BIRTH HISTORY

Did the mother have any accidents, illnesses, or other unusual complications during pregnancy? Yes No

If yes, please explain. _____

Was medication used during labor or delivery? Yes No

If yes, please explain. _____

Age of mother at child's birth _____. Length of pregnancy _____

Birth weight of child _____

CONDITIONS IMMEDIATELY FOLLOWING BIRTH

Was your baby incubated? Yes No If yes, for how long? _____

Did your infant have difficulties breathing? Yes No

Was your infant given oxygen? Yes No

Was your infant jaundiced? Yes No

Did your infant have any of the following? Swallowing difficulties _____ Feeding problems _____

Seizures _____ Sores or bruises _____ Cleft lip or palate _____

Was birth weight regained quickly? Yes No

MEDICAL HISTORY

Check the illness which your child has had and the child's age at the time of the illness:

- | | | |
|---|----------------------------------|---------------------------|
| _____ Mumps _____ | _____ Chicken Pox _____ | _____ Small Pox _____ |
| _____ Tonsillitis _____ | _____ Asthma _____ | _____ Influenza _____ |
| _____ Tuberculosis _____ | _____ Convulsions _____ | _____ Allergies _____ |
| _____ Frequent colds _____ | _____ Epilepsy _____ | _____ Encephalitis _____ |
| _____ High Fever _____ | _____ Whooping cough _____ | _____ Scarlet fever _____ |
| _____ Pneumonia _____ | _____ Hay Fever _____ | _____ Measles _____ |
| _____ Chronic ear infections _____ | _____ Appendicitis _____ | _____ Polio _____ |
| _____ Lead Poisoning _____ | _____ Head Injury _____ | _____ Meningitis _____ |
| _____ Reflux _____ | _____ Autism Spectrum Dis. _____ | _____ ADHD/ADD _____ |
| _____ Feeding/Swallowing Difficulties _____ | | |
| _____ Other _____ | | |

Were any of the illness listed above followed by a noticeable change in your child's behavior, speech language and/or hearing abilities? Yes No

If yes, please explain. _____

Was your child ever hospitalized? Yes No How long? _____

If yes, please explain. _____

Has your child ever had any severe accidents? Yes No

If yes, please explain. _____

MEDICATIONS

ALLERGIES

PREVIOUS EXAMINATIONS AND TREATMENTS

(Please indicate when, where, and by whom.)

Speech-Language
Evaluation/Therapy _____

Occupational
Evaluation/Therapy _____

Hearing Evaluation _____

Ear, Nose and Throat _____

Neurological _____

Psychological _____

Educational _____

DEVELOPMENTAL MILESTONES

Please indicate at what age your child developed the following skills.

_____ Crawl	_____ Walk	_____ First word
_____ Combined words	_____ Toilet trained	_____ Sit

SPEECH

Can you understand your child's speech? Always Sometimes Rarely
Do others have difficulties understanding your child's speech? Always Sometimes Rarely
Does your child have difficulties producing certain sounds? Yes No
Does your child repeat sounds or words and/or appear to stutter when speaking? Yes No
Is his/her speech accompanied by unpleasant movements or facial expressions? Yes No

VOICE

Does your child's voice sound? High Low Soft Loud
Is the child's voice hoarse? Yes No

LANGUAGE

Does your child seem to understand directions/commands? Always Sometimes Never
Does your child seem to ignore instructions or appear to be confused? Always Sometimes Never
Does your child initiate talk? Always Sometimes Never
Does your child respond to others talk? Always Sometimes Never
Does your child comment on daily activities? Always Sometimes Never
Does your child talk to request needs and wants? Always Sometimes Never
Does your child answer questions? Always Sometimes Never

VOCABULARY

How many words does your child use? _____
Does your child use: Single Words Two to Three Word Combinations Sentences

SOCIAL / PLAY

Does your child respond to others in his/her environment? Always Sometimes Never
Does your child play with others? Always Sometimes Never
Does your child initiate contact with others? Always Sometimes Never
Does your child imitate sounds or words? Always Sometimes Never
Does your child play appropriately? Always Sometimes Never
Does your child play with a variety of toys? Always Sometimes Never
Does your child take turns? Always Sometimes Never
Does your child tell stories? Always Sometimes Never
Does your child listen to others? Always Sometimes Never
Does your child comment appropriately regarding what people say? Always Sometimes Never

READING / SPELLING

Does a family member have a learning disability or dyslexia? Yes No
Does your child have difficulties learning the alphabet? Yes No
Does your child have difficulties pronouncing the letters in words? Yes No
Does your child have difficulties reading despite additional remediation or tutoring? Yes No
Does your child have difficulties spelling? Yes No
Is your child a slow reader? Yes No
Does your child have to re-read sentences to understand the meaning? Yes No
Does your child dislike or avoid reading? Yes No
Does your child enjoy going to school? Yes No
Does your child have difficulties in certain subjects? Yes No

BEHAVIOR

Does your child eat well? Yes No
Is your child considered a picky eater? Yes No
What are his/her favorite snacks? _____
Does your child sleep well? Yes No
Does your child have difficulty concentrating? Yes No
Is discipline difficult at home? Yes No
Does your child play with toys appropriately? Yes No
Does your child exhibit preservative behaviors? (i.e. spinning objects, opening and closing doors) Yes No
What are your child's favorite toys/games? _____

Check the traits that describe your child:

____ Easily makes friends	____ Withdrawn	____ Temper tantrums
____ Stubborn	____ Uncooperative	____ Cooperative
____ Shy	____ Happy	____ Other _____

FAMILY HISTORY

Please list family members in the home:

1) _____	mother/father/sibling/other
2) _____	mother/father/sibling/other
3) _____	mother/father/sibling/other
4) _____	mother/father/sibling/other
5) _____	mother/father/sibling/other
6) _____	mother/father/sibling/other

Do other family members have communication, learning disabilities, fine, or gross motor difficulties?

Please list:

EDUCATION

Please list school/daycare and grade your child is in. _____

Does your child have a (please circle) I.E.P., 504 Plan, other resources/tutoring? Please explain below.

Sensorimotor History

Tactile Processing: Does the child:

- | | | |
|---|---|---|
| • Object to being touched? | Y | N |
| • Dislike being cuddled? | Y | N |
| • Dislike the feeling of certain fabrics? | Y | N |
| • Dislike to have his/her socks/shoes on? | Y | N |
| • Dislike having his/her face washed? | Y | N |
| • Dislike having his/her hair washed/brushed? | Y | N |
| • Dislike having his/her teeth brushed? | Y | N |
| • Want tags cut out of his/her clothes? | Y | N |
| • Dislike playing in messy materials? | Y | N |
| • Underreact/ overreact to getting hurt? | Y | N |

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Auditory Processing: Does the Child:

- | | | |
|--|---|---|
| • Cover his/her ears in reaction to loud sounds? | Y | N |
| • Seem under-responsive to noises? | Y | N |
| • Miss some sounds? | Y | N |
| • Like to make loud noises? | Y | N |
| • Become easily distracted by background noises? | Y | N |
| • Have a diagnosed hearing problem? | Y | N |
| • Have a diagnosed speech problem? | Y | N |

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Visual Processing: Does the Child:

- | | | |
|--|---|---|
| • Have a diagnosed visual deficit? | Y | N |
| • Loose his/her place while reading/writing? | Y | N |
| • Display poor eye contact? | Y | N |
| • Appear sensitive to light? | Y | N |
| • Make reversals during reading/writing? | Y | N |

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Olfactory and Gustatory Processing: Does the Child:

- | | | |
|--|---|---|
| • Smell non-food items? | Y | N |
| • Lick or mouth non-food items? | Y | N |
| • React negatively to smell? | Y | N |
| • Eat a limited variety of food? | Y | N |
| • Seem unaware of tastes or smells? | Y | N |
| • Gag or vomit in reaction to tastes/smells? | Y | N |

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Proprioceptive Processing: Does the Child:

- | | | |
|----------------------------------|---|---|
| • Love to be held tightly? | Y | N |
| • Push hard on people/objects? | Y | N |
| • Seek pressure on his/her body? | Y | N |
| • Head bang intentionally? | Y | N |

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Vestibular Processing: Does the Child:

- | | | |
|--|---|---|
| • Always seem to be on the “go?” | Y | N |
| • Enjoy spinning activities, but never seems to get dizzy? | Y | N |
| • Avoid balance activities? | Y | N |
| • Become fearful if their feet leave the ground? | Y | N |
| • Appear to be clumsy? | Y | N |

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Regulatory concerns: Does the child:

- | | | |
|--|---|---|
| • Have difficulty with bowel/bladder training? | Y | N |
| • Smear feces? | Y | N |
| • Have difficulty with sleeping patterns? | Y | N |
| • Have poor appetite control? | Y | N |
| • Have difficulty attending? | Y | N |
| • Display an unusually high/low energy level? | Y | N |
| • Have excessive emotional/behavioral outbursts? | Y | N |

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Muscle Tone: Does the child:

- | | | |
|--|---|---|
| • Tire/ fatigue quickly? | Y | N |
| • Display poor muscle strength? | Y | N |
| • Prop his/her head up when writing/drawing? | Y | N |
| • Prefer to lie on his/her back rather than their stomach? | Y | N |
| • Prefer sedentary activities? | Y | N |
| • Display a weak grasp on writing or eating utensils? | Y | N |
| • Hold his/her mouth open unnecessarily? | Y | N |

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Additional Comments:
