PATIENT INFORMATION, THERAPY AUTHORIZATION AND RELEASE FORM

All information must be filled out completely

Patient Info

Name: _____ DOB: _____ Sex: ____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (home) _____ (cell) _____ (email) _____

School/Daycare: _____

Physician Info

Referring Physician Name: _____ Physician Practice Name: _____

Other Physicians involved**:** _____

Emergency Contact (please do not use the parents)

Name: _____ Phone: _____ Relationship to Patient: _____

Guardian #1

Name: _____ DOB: _____ Relationship to Patient: _____

SSN: _____ Driver's License #: _____ Driver's License State: _____

Address (if different from patient): _____ City: _____ State: ____ Zip: _____

Phone: (home) _____ (cell) _____ (email) _____

Employer: _____ Phone: _____

Guardian #2

Name: _____ DOB: _____ Relationship to Patient: _____

SSN: _____ Driver's License #: _____ Driver's License State: _____

Address (if different from patient): _____ City: _____ State: ____ Zip: _____

Phone: (home) _____ (cell) _____ (email) _____

Employer: _____ Phone: _____

PRIMARY INSURANCE COVERAGE INFORMATION:

Insurance Co. Name: _____ Policy#: _____

Group#: _____

Policy Holder's Full Name: _____ SSN: _____

Policy Holder D.O.B.: _____ Relationship to Patient: _____

Policy Holder's Employer: _____ Employer's Phone #: _____

Policy Holder's Address (if different from patient):

Street: _____City: _____State: ____Zip: _____

SECONDARY INSURANCE COVERAGE INFORMATION:

Insurance Co. Name: _____ Policy#: _____

Group#: _____

Policy Holder's Full Name: _____ SSN: _____

Policy Holder D.O.B.: _____ Relationship to Patient: _____

Policy Holder's Employer: _____ Employer's Phone #: _____

Policy Holder's Address (if different from patient):

Street: _____City: _____State: ____Zip: _____

Does your child have a Medicaid Policy? Yes _____ No _____

Does your child receive BabyNet Services? Yes _____ No _____

BabyNet Company: _____

Early Interventionist (E.I.): _____

Charleston Children's Therapy Center

9565 Highway 78
Building 700, Suite 102
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Fax: 843.569.4535
www.charlestonctc.com

INSURANCE INFORMATION:
As a courtesy to our patients, we will verify and file your insurance; however, we cannot guarantee payment. We suggest that you read your policy manual as it pertains to therapy coverage. Many insurance companies have stipulations, such as usual and customary fees (UCR), limited therapy sessions, limited reimbursable amounts per session, deductibles, co-payment/co-insurance, etc. Such stipulations should be indicated in your policy manual or available by calling your insurance provider. **You are responsible for amounts not covered by your insurance. We have an agreement with you, not your insurance company, for receipt of payment.** Please be aware of this and plan to make payments accordingly. By signing this agreement, you authorize payment of medical benefits to Charleston Children's Therapy Center, LLC for services rendered to me.

PAYMENT POLICY & BILLING PROCEDURES:

1. **You are responsible for the percentage, co-pay, deductible or any other amount not covered by your insurance company.** This payment is due when services are rendered unless other arrangements have been approved.
2. If insurance information is not available or you do not have insurance, payment is due when services are rendered, unless other arrangements have been approved.
3. At your request, you may receive receipts and/or a monthly statement that will show you the status of your account.
4. If no form of payment is received within a three-month period the account will be sent to collections. Please be advised any amount sent to collections will be reflected on your credit history.

CONSENT TO TREATMENT:

1. I understand that I have been referred for therapy services and care with Charleston Children's Therapy Center, LLC.
2. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist.
3. By signing this agreement, I consent to have Charleston Children's Therapy Center, LLC provide treatment and care as prescribed by my physician and/or as my therapist recommends.

RELEASE OF INFORMATION:
I hereby authorize the release of information and/or medical records to Charleston Children's Therapy Center, LLC for the purpose of evaluation and treatment for the above-named patient. I authorize Charleston Children's Therapy Center, LLC to release information and/or medical records to any and all physicians, hospitals, schools, agencies, individuals and insurance companies involved in the above-named patient's care.

USE AND DISCLOSURE:
I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Charleston Children's Therapy Center, LLC. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

I certify by my signature that I have read the above and agree to these policies.

Guardian Signature: _____ Date: _____

Relationship to Patient: _____

Witness: _____

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Photograph / Video Release for Minors

- ❑ I grant permission to Charleston Children's Therapy Center to use photographs/videos of my minor child for the purpose of evaluation, treatment, and measure of progress of therapy.
- ❑ I grant permission to Charleston Children's Therapy Center to use photographs/videos of my minor child in print or in online materials designed for promotional and informational purposes.
- ❑ I do not grant permission to Charleston Children's Therapy Center to photograph, or video record my child.

I hereby release and discharge Charleston Children's Therapy Center from all and any claims and demands ensuing from or in connection with the use of the photographs/videos, including any and all claims for libel and invasion of privacy.

I am the parent/guardian of the below named minor. I hereby consent to the above on his/her behalf.

Patient Name: _____

Guardian Name: _____

Guardian Signature: _____ Date_____

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Cancelation Policy
Charleston Children's Therapy Center, LLC

We never double book appointments. We believe that this scheduling policy is great for our patients – our providers are always ready for you at your scheduled appointment time!

Cancelations within 24 hours of your appointment have a significant impact on our ability to serve the greater Charleston Community while low attendance jeopardizes a patient's plan of care.

- **Cancelation Fee:** A $25.00 cancelation fee will be charged for any No Show. We consider a No Show an appointment(s) that are either missed or canceled without 24 hours of notice (emergency exception: sudden illness or accident). By signing this agreement, you agree to pay this cancelation fee. Insurance will not cover this fee.
- **Removal from Schedule – No Show:** Two No Shows within any six-month period will result in a patient being discharged for failure to comply with our attendance policy.
- **Removal from Schedule - Attendance:** Attendance below 80% will result in a patient being discharged for failure to comply with our attendance policy. Appointments may be rescheduled when possible to facilitate compliance with this policy. Excused appointments will not negatively impact attendance.

We thank you in advance for your cooperation!

Patient Name: _____

Guardian Signature: _____Date: _____

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Therapy Session Policy
Charleston Children's Therapy Center, LLC

Caregivers/Guardians are required to be immediately accessible during their child's entire therapy session. Accessibility enhances communication, improves scheduling/billing coordination, and helps to ensure the safety of all our patients and staff in the event of an emergency.

We continue to encourage social distancing per our COVID-19 safety protocols. If you are waiting outside or in your car, please be sure your contact information is up to date in our system and do not leave the premises.
Thank you for your full cooperation and understanding in this matter.

_____ _____
Parent/Guardian Signature Date

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Behavioral Protocol

At CCTC, safety for patients and therapists is our top priority. Our occupational and speech therapists treat behavior and identify if it is due to communication frustrations or sensory regulation issues. If a child displays any behaviors such as: hitting, biting, pinching, or throwing behavior, we inform parents and write an incident report.

- For the first incident, we inform the parent, document in the daily note, and write an incident report.
- For the second incident, we complete an incident report, notify the lead therapist, and see if able to sit in on a session, and request the parent to wait in the waiting room for future sessions.
- For the third incident, we follow the same process as the first two, and if needed, ask the lead therapist or parent to sit in on a session.
- For the fourth incident, we follow the same process as above and inquire about ABA therapy. If actively receiving ABA therapy, consider having the ABA therapist join a session.
- For the fifth incident, we complete an incident report, send a referral request for psychiatric evaluation and/or ABA therapy. If necessary, we place the patient on hold until outside evaluations are completed or discharge them from services.

At any point, if a therapist does not feel safe continuing treatment, we may place the patient on hold or discharge them and refer them for a psychiatric/behavioral evaluation. These steps ensure the safety of patients and staff.

Guardian Signature: _____ Date: _____

Relationship to Patient: _____

Witness: _____

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Patient Questionnaire

Today's Date: _____

Child's name: _____ Date of Birth: _____
Parent/Caregiver name(s): _____
Physician Name: _____ Physician Practice Name: _____
Please list language(s) spoken in the home: _____
Medical Diagnosis: _____
Who Does the Child Live With (ie: Siblings in home, Grandparents in home, Other Family Members):_____

Please check yes or no to each item and write any remarks/comments to further explain, where necessary.

Pregnancy/Delivery History:

	Yes	No	Remarks/Comments
1. Were any complications experienced during pregnancy (i.e. illness, injury, bleeding, anemia, operations, hypertension, high blood pressure, etc). ***If yes, please specify.***	____	____	_____ _____ _____ _____
2. Were any drugs or medications taken during pregnancy? ***If yes, please specify.***	____	____	_____ _____
3. Was the pregnancy full term? If not, how early or late was the pregnancy?	____	____	_____ _____
4. Was it a breech or caesarean delivery? ***If yes, please specify.***	____	____	_____
5. Were forceps used?	____	____	_____

Newborn History:

	Yes	No	Remarks/Comments
1. What was your child's birth weight? _____			_____
2. How long did your child remain in the hospital? _____			_____
3. Were there any of the following complications (***if yes, please specify***):			
• cyanosis	____	____	_____

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- jaundice ____ ____ _____
- seizures ____ ____ _____
- apnea (oxygen deprivation) ____ ____ _____
- cardiac complications ____ ____ _____
- birth defects ____ ____ _____

4. Was there a need for oxygen/ventilator? ____ ____ _____
5. Was there a need for tube feedings? ____ ____ _____

Medical History:

	Yes	No	Remarks/Comments
1. Has your child had any of the following (specify dates). ***If yes, please specify***.			
• tonsils/adenoids removed	____	____	_____
• ear tube placement	____	____	_____
• asthma	____	____	_____
• sinusitis	____	____	_____
• meningitis	____	____	_____
• scarlet fever	____	____	_____
• diabetes	____	____	_____
• seizures	____	____	_____
• lung difficulties	____	____	_____
• heart defect	____	____	_____
• tuberculosis	____	____	_____
• physical injuries	____	____	_____
• surgical procedures	____	____	_____
• other	____	____	_____
2. Does your child have any allergies? ***If yes, please specify.***	____	____	_____ _____
3. Is your child currently taking any medications? ***If yes, please specify.***	____	____	_____ _____
4. Does your child have a vision problem? ***If yes, please specify.***	____	____	_____ _____
5. Does your child have a history of ear infections? ***If yes, please specify.***	____	____	_____ _____
6. Are immunizations up to date?	____	____	_____

7. Has your child been exposed to HIV, Hepatitis B or tuberculosis? ***If yes, please specify.*** _____ _____ _____

8. Is your child currently receiving therapy Services? If yes, for which disciplines? _____ _____ _____

Developmental History:

	Age	Remarks/Comments
At what approximate age did your child:		
• roll over both ways	_____	_____
• sit alone	_____	_____
• crawl (hands and knees)	_____	_____
• pull to stand	_____	_____
• stand alone	_____	_____
• walk alone	_____	_____
• first "meaningful" word	_____	_____
• drink from cup	_____	_____
• use a spoon	_____	_____
• independent feeding	_____	_____
• toilet-trained	_____	_____

Describe how your child communicates wants/needs (for example: gestures, pointing, pulling/pushing behaviors):

_____
_____
_____
_____

Are there, or has there ever been a history of feeding problems? (for example: sucking, swallowing, drooling, chewing, reflux, food aversions, gagging):

_____
_____
_____

Does your child have difficulty walking, running or have frequent falls?

_____
_____
_____

Describe your child's present behavior (for example: short attention span, frequent temper tantrums, quiet, gets along well with others, resistant to change):

_____
_____
_____

	Yes	No	Date/By Whom
Has your child had any of the following examinations ***(If yes, please specify):***			
• neurology	____	____	_____
• orthopedics	____	____	_____
• audiology	____	____	_____
• genetics	____	____	_____
• psychiatry	____	____	_____
• psychology	____	____	_____
• physical therapy	____	____	_____
• occupational therapy	____	____	_____
• speech therapy	____	____	_____

Please list primary concerns for your child, and any other information you feel is of importance:

_____
_____
_____
_____
_____
_____
_____