Professional Therapy Associates, LLC
Sensory Gym and Rehabilitation Services

2557 Hooper Avenue, Brick, NJ 08723
Phone: (732) 701-3711 ● Fax: (732) 701-3709 ● ptasensorygym@yahoo.com

Identifying Information:
Child's Name: _____ Birthdate: _____ Sex: □ M □ F
Name (s) child goes by: _____
Diagnosis (es): _____
_____
_____
Date of Diagnosis: _____

Parent's Information:
Father's Name: _____ Date of Birth: _____
SSN: _____ Home Phone: _____
Cell Phone: _____ Other: _____
Address:_____ City/State/Zip: _____
E-mail: _____ Employer: _____

Mother's Name:_____ Date of Birth: _____
SSN: _____ Home Phone: _____
Cell Phone: _____ Other: _____
Address: _____ City/State/Zip: _____
E-mail: _____ Employer: _____

Emergency Contact: _____

Primary Phone #: _____ Relationship to Child: _____

Child lives with (check one):
□ Birth Parents □ Foster Parents □ One Parent
□ Adoptive Parents □ Parent and Step-Parent □ Other _____

Other children in the family:
Name Age Sex Grade Developmental Problems
_____
_____
_____
_____

Is there a language other than English spoken in the home? □ Yes □No
If yes, which one?_____
Does the child speak the language? □ Yes □ No
Does the child understand the language? □ Yes □No

Birth Information:

□ Full Term □Premature Gestational Weeks _____ Birth Weight: _____
□Vaginal □ C-Section

Pregnancy or Delivery Complications:_____
_____

Has your child had any of the following? (check all that apply as a yes)

□ adenoidectomy	□ encephalitis	□seizures	□ sinusitis	□ head injury
□ chronic colds	□ measles	□ tonsillectomy	□ breathing difficulties	□ flu
□ chicken pox	□ high fevers	□ thumb/finger sucking habit	□sleeping difficulties	□ mumps
□ ear infections	□ meningitis	□ tonsillitis	□ vision problems	□ bronchitis
□ ear tubes	□ scarlet fever	□ asthma	□ hay fever	□ convulsions
□ kidney disease	□ whooping cough/croup			

Other serious injury/surgery: _____
Is your child currently (or recently) under a physician's care? □ Yes □ No
If yes, why? _____
_____

Please list any medications your child takes regularly: _____
_____

Allergies: _____

Dietary restrictions: _____

Assistive Devices: _____
_____

Primary Care Physician: _____ Phone #: _____

Please tell the approximate age your child achieved the following developmental milestones:

_____ sat alone	_____ grasped crayon/pencil	_____ babbled
_____ said first words	_____ put two words together	_____ spoke in short sentences
_____ walked	_____ toilet trained	

Does your child...

Y□ N □ choke on food or liquids?
Y□ N □ currently put toys/objects in his/her mouth?
Y□ N □ brush his/her teeth and/or allow brushing?
Y□ N □ drool?
Y□ N □ refuse any food tastes, textures, or temperatures?
Y□ N □ suck his/her thumb?
Y□ N □ use a pacifier?

Your child currently communicates using...
Y□ N □ body language.
Y□ N □ sounds (vowels, grunting).
Y□ N □ words (shoe, doggy, up).
Y□ N □ 2 to 4 word sentences.
Y□ N □ sentences longer than four words.
□ other _____.

Does your child...
Y□ N □ transition well to new routines?
Y□ N □ repeat sounds, words or phrases over and over?
Y□ N □ understand what you are saying?
Y□ N □ retrieve/point to common objects upon request (ball, cup, shoe)?
Y□ N □ follow simple directions ("Shut the door" or "Get your shoes")?
Y□ N □ respond correctly to yes/no questions?
Y□ N □ respond correctly to who/what/where/when/why questions?
Y□ N □ feed himself?
Y□ N □ dress himself?
Y□ N □ wear glasses?
Comments: _____
_____

Behavioral Characteristics:
Y□ N □ eating problems
Y□ N □ sleeping problems
Y□ N □ toilet training problems
Y□ N □ difficulty concentrating
Y□ N □ needs a lot of discipline
Y□ N □ difficult to manage
Y□ N □ underactive
Y□ N □ overactive
Y□ N □ irritable
Y□ N □ separates from parents easily
Y□ N □ transitions well to new routines
Y□ N □ excitable
Y□ N □ laughs easily
Y□ N □ sensitive
Y□ N □ gets along with adults
Y□ N □ plays well with children
Y□ N □ prefers playing alone
Y□ N □ makes friends easily
Y□ N □ uses toys appropriately
Y□ N □ happy
Y□ N □ alert to gestures
Y□ N □ self-abusive behavior
Y□ N □ willing to try new activities
Y□ N □ plays alone for reasonable length of time
Y□ N □ easily frustrated/impulsive
Y□ N □ cooperative
Y□ N □ attentive
Y□ N □ easily distracted/short attention
Y□ N □ destructive/aggressive
Y□ N □ inappropriate behavior
Y□ N □ restless
Y□ N □ poor eye contact
Y□ N □ withdrawn
Y□ N □ stubborn

Comments: _____
_____
_____

If your child is in school, please answer the following:
Name of school: _____ Grade: _____
_____
Teacher's name: _____
Has your child repeated a grade? If yes, which grade? _____
What are your child's strengths and/or best subjects? _____
_____
Is your child having difficulty with any subjects? _____
_____

Has he/she ever had a speech, occupational, or physical therapy evaluation/screening? □ Yes □ No
If yes, where and when? _____
_____
_____
_____

Has he/she ever had a hearing evaluation/screening? □ Yes □ No
If yes, where and when? _____
_____
_____

Form Completed By: _____ Relationship to Child: _____

Insurance Information:

Primary Insurance Company: _____
Policy Holder: _____ Date of Birth: _____
Relationship to Patient: _____
Policy Number: _____ Group #: _____

Secondary Insurance Company: _____
Policy Holder: _____ Date of Birth: _____
Relationship to Patient: _____
Policy Number: _____ Group #: _____

Party Responsibility for payment: □ Mother ◘ Father □ other (fill out below)
Name: _____
Address: _____ City/State/Zip: _____
Phone Number: _____

For our patients who have insurance that Professional Therapy Associates does not participate with, payment is due at the time of service. Professional Therapy Associates can give you an invoice to submit to your insurance company however will only be given if requested. Some plans have a deductible which is the patient's responsibility. Some policies require authorization or a referral for visits. If a referral is required by your insurance, it is the patient's responsibility to get a referral from the primary care doctor prior to the visit. If the referral is not obtained, the patient may be responsible for the fees accumulated for the visits. All authorizations will be confirmed by Professional Therapy Associates prior to the initial visit. When your insurance policy requires copay, this payment is requested at arrival, prior to the visit. Because insurance companies have many different plans, it is important that each individual understands their specific policies. A budget plan may be arranged if deemed necessary by Professional Therapy Associates and determined before the initial visits.

I have had a chance to ask questions regarding the billing and insurance policies and give Professional Therapy Associates permission to bill my insurance company on my behalf.

_____ _____
Signature Date

Relationship to Patient: _____

Professional Therapy Associates, LLC
2557 Hooper Avenue
Brick, NJ 08723
Phone: 732-701-3711 Fax: 732-701-3709

Authorization to Receive Information

To: _____

_____

_____

Re: _____
Name

_____
Date of Birth

Professional Therapy Associates, LLC is requesting that you provide copies of:

Regarding the above patient. All information is considered confidential.

I hereby authorize Professional Therapy Associates, LLC to receive your records on the above-named patient.

_____
Signature (Parent if minor)

_____
Witness (may be therapist)

_____
Date

Professional Therapy Associates, LLC
2557 Hooper Avenue
Brick, NJ 08723
Phone: 732-701-3711 Fax: 732-701-3709

Authorization to Release Information

Patient's Name: _____

Birth Date: _____

Address: _____

_____

_____

I hereby authorize Professional Therapy Associates, LLC to release information concerning therapy evaluations and treatments of the above-named patient to the following person(s) or agencies:

1. Name/ Agency: _____

   Address: _____

2. Name/ Agency: _____

   Address: _____

3. Name/ Agency: _____

   Address: _____

I do not want any forms to be sent at this time: _____ (initial) _____ (date)

I would like a report sent directly to patient's address: _____ (initial) _____(date)

This authorization may be revoked at any time upon written request except to the extent that action has already been taken. All information will be considered confidential. A Xerox copy of this form will be considered valid. This authorization is in effect for one year from the date signed below.

_____ _____

Signature (specify relationship if patient is a minor) Date

_____

Witness (may be therapist)

Professional Therapy Associates, LLC
Sensory Gym and Rehabilitation Services

2557 Hooper Avenue, Brick, NJ 08723
Phone: (732) 701-3711 ● Fax: (732) 701-3709 ● ptasensorygym@yahoo.com

PERMISSION for MEDIA USE

PATIENT NAME: _____

BIRTHDATE: _____

Professional Therapy Associates, LLC Sensory Gym and Rehabilitation Services will occasionally take photos or videos of the client during therapy sessions for purposes of therapy, marketing, advertising, etc. I understand that photos or videos of my child may be used in brochures, newsletters, social networking sites, etc. and authorize such use.

_____ _____
Parent Signature Date

_____
Witness

☐ I would not like my child's picture taken at this time. _____
Parents Initials

Professional Therapy Associates, LLC
2557 Hooper Avenue
Brick, NJ 08723
Phone: 732-701-3711 Fax: 732-701-3709

Attendance Policy

Patient Name: _____

The purpose of Professional Therapy Associates, LLC is to provide Occupational, Physical, Speech and Social Group Therapy to those individuals in which it is recommended.

It is expected that patients enrolled in therapy will attend all scheduled sessions and will participate in the program planned for him/her. If a patient does not show up for the appointment and does not provide 24 hour notice, there will be a $50.00 charge. If a patient misses two (2) successive sessions or three (3) sessions in a calendar month without an acceptable excuse or without notifying Clinic Personnel, he/she will be dismissed from therapy.

Readmission will be made only upon request by the patient to the Clinic Director.

I have read the above policy and accept these conditions.

_____ _____
Signature of patient, parent, spouse or guardian Witness

_____
Date

Professional Therapy Associates, LLC

PATIENT RECORD OF DISCLOSURES

In general, The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (*PHI).* The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individuals office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home telephone _____
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work telephone _____
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Written Communication
  - ☐ O.K. to mail to my home address
  - ☐ O.K. to mail to my work/office address
  - ☐ O.K. to fax to this number
- ☐ Other _____

_____ _____ _____

Patient/Guardian Signature Print Name Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

OFFICE USE ONLY

****

Record of Disclosures of Protected Health Information

Date	Disclosed to	1	Purpose of Disclosure	By Whom Disclosed	2	3

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; O=Other

New Patient Consent to the Use and Disclosure of Health Information

For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, **Professional Therapy Associates, LLC** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that **Professional Therapy Associates, LLC** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **Professional Therapy Associates, LLC** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Professional Therapy Associates, LLC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____

Patient/Guardian Signature

_____

Date

Professional Therapy Associates, LLC
2557 Hooper Avenue
Brick, NJ 08723
Phone: 732-701-3711 Fax: 732-701-3709

Notice of Therapist Cancellation

At Professional Therapy Associates, LLC we pride ourselves on providing trained therapeutic services to our patients. In the event of a patient's regular therapist being absent we will try to provide a temporary replacement to ensure that all our patients receive the therapy they need.

I hereby understand that Professional Therapy Associates, LLC will try to provide a temporary therapist in the event of my child's regular therapist being absent.

_____
Signature (Parent if minor)

_____
Witness (may be therapist)

_____
Date

Financial Policy

We are pleased that you have chosen Professional Therapy Associates, LLC for your child (ren) s needs. It is our goal to provide you with the highest quality services possible. In choosing our services, you have accepted the financial responsibility to ensure full payment for our services.

Date: _____

Patients Name(s): _____

Insurance Carrier**:** _____

Insurance ID**#:** _____

Date verified: _____ Employee Initials: _____

OUR POLICY REGARDING:

____ **Private Pay**: Patient agrees to pay PTA at the time of treatment for services rendered. We will provide a superbill when requested, which can be used to submit claims for reimbursement or kept for personal records. The fees for private payment are as follows: Initial Evaluation $250.00, Individual sessions $40.00 per half hour.

____**Major Medical**: Your major medical insurance coverage is a contract between you and your insurer. As a courtesy to you PTA will bill your insurance carrier (s) directly. You are responsible for any deductible and co-payment or coinsurance that is determined by your insurance carrier.

We have verified your insurance benefits for Occupational/Physical/Speech Therapy

They are as follows:

Yearly Deductible $_____ Amount met to date $_____Coinsurance _____%

#of Yearly Visits allowed _____Co-payment $_____Referral Needed? Y/N

Authorization Required after Initial Evaluation? Y/N

Additional Notes:

_____

_____

IT IS YOU RESPONSIBILITY TO TRACK THE NUMBER OF VISITS AUTHORIZED AND THE VALID PERIOD OF EACH REFERRAL AND PRESCRIPTION. FAILURE TO DO SO MAY RESULT IN TREATMENT THAT IS NOT AUTHORIZED BY YOUR INSURANCE CARRIER, AND ANY CHARGES INCURRED FOR THESE UNAUTHORIZED VISITS WILL BE YOUR FULL RESPONSIBILITY. I have read the above policy regarding my financial responsibility to PTA for providing services to my child (ren). I agree to pay PTA the full and entire amount of all bills incurred by my child (ren); or any amount due after insurance payment has been made by my carrier. I understand that my failure to comply with the financial policies of PTA may cause interruptions in my child (ren) s treatment schedule.

I understand that it is my responsibility to inform that this office of any correspondence that I receive from my insurance company notifying me of a change or denial/cessation of payment for services.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

Responsible party signature: _____Date_____

Professional Therapy Associates, LLC
2557 Hooper Avenue
Brick, NJ 08723
Phone: 732-701-3711 Fax: 732-701-3709

Below and check off **ALL** the days of availability and comment the time(s) your child would be available for continued weekly services. We will make every effort to accommodate your specific needs.

Childs Name: _____

Service: _____

Monday
Times available:
_____
_____

Tuesday
Times available:
_____
_____

Wednesday
Times available:
_____
_____

Thursday
Times available:
_____
_____

Friday
Times available:
_____
_____

Saturday
Times available:
_____
_____

Sunday
Times available:
_____
_____

Professional Therapy Associates, LLC Credit Card on File Policy (2017)

To Our Patients:

We have implemented a policy requiring an active credit card held on file effective 2/21/2017. As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans required deductibles, copayments, and coinsurances in amounts that may not be known to you or us at the time of your visit.

Similar to hotels and car rental agencies, you are asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share, you will receive a statement. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

What we will charge to your account

1. Your copay if you choose not to pay with another form of payment at time of service
2. Any deductible that you're insurance company applies
3. Any coinsurances your insurance company applies
4. A fee for excessive cancelations and or fee for no call no show appointments as per our policy. You will find the policy information by the front door and the door to the treatment room.

Also remember that this policy does not restrict your right to appeal any charge made to your credit card. Should you feel that we have charged your card in error, you may contact our billing office. If a mistake has been made we will reverse the charges.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely,

Professional Therapy Associates LLC

Credit Card on File Authorization Form

Please fill out the details as indicate below.

Card Holders Name as it appears on Card:

_____

Card Number: _____

Expiration Date: _____

CCV (Number on back of card) :_____

Card Type:

Visa { } MasterCard { } Discover { }

Card Holders Signature: _____

Date: _____

I have read and agreed to Professional Therapy Associates LLC financial policy. I hereby authorize Professional Therapy Associates LLC to charge the credit card listed above for payment of charges to my account.

This form will be kept on file and will remain in effect until the expiration of the credit card account.

_____

Office Use Only

Patient Name: _____

Cardholder in relationship to Patient: _____