Professional Therapy Associates, LLC
Sensory Gym and Rehabilitation Services
2557 Hooper Avenue, Brick, NJ 08723
Phone: (732) 701-3711 ● Fax: (732) 701-3709 ● info@ptasensorygym.com

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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: _________________________
Cell Phone: ________________________________ Home Phone: _________________________
Address:___________________________________ City/State/Zip: ________________________
E-mail: ____________________________________ Employer: ____________________________

Mother's Name:_____________________________ Date of Birth: _________________________
Cell Phone: ________________________________ Home Phone: _________________________
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

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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?

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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 □ 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
Y□ N □ alert to gestures

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
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 your child has ever received services in the past including early intervention?

Service:	**Location:**	**Time period:**
OT		
SLP		
PT		
ABA		
Other Services		

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

Form Completed By: ________________________________ Relationship to Child: __________________

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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: __________________________

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full. 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 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_______________

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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 of Minor)

____
Witness (May be Therapist)

____
Date

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Authorization to Release Information

Patient's Name: ______________________________
Date of birth: ______________________________
Address: ______________________________
____
____

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

1. Name/ Agency ____

   Address ____

2. Name/ Agency ____

   Address ____

3. Name/ Agency ____

   Address ____

I do not want any forms to be sent at this time:
________________(Date) ________________(Initial)
I would like a report sent directly to patient's address:
________________(Date) ________________(Initial)

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 from one year from the date signed below.

______________________________ ______________________________
Signature (Parent of Minor) Date

______________________________ ______________________________
Witness (May be Therapist) Date

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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

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Attendance Policy

Purpose: To ensure appropriate communication and coordination with Professional Therapy Associates (PTA) and client/ caregiver(s)

Agency Responsibility

- To communicate with the caregiver about the treatment schedule
- To communicate with the caregiver about day/ time changes in treatment schedule
- Try to provide temporary replacement of a therapist if the regular therapist is absent
- T**o reschedule missed visits whenever possible**

Caregiver Responsibility

- To notify agency within 24 hours of a cancelation or reschedule a session
- 80% attendance rate must be maintained each month

Client/Caregiver Non- Compliance

- 2 no show/no contact appointments without prior notice given to the office of therapist within a 30-day period or 20% cancelation rate will result in a non-compliance status in which the agency will issue a letter of notification to the home and client will be placed on hold and arrangements for readmission must be made with the clinical supervisor.

* If the Caregiver does not give 24 hours' notice of a cancelation, there will be a $50 fee per session.

_______________________________________ _________________________

Parent Signature Date

____

Witness

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Patient Record of Disclosures

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

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

☐ Home telephone _______________
☐ Okay to leave messages with detailed information
☐ Leave message with call- back number only

☐ Written Communication
☐ Okay to mail to my home address
☐ Okay to mail to work/office address
☐ Okay to fax to this number

☐ Work telephone _______________
☐ Okay to leave messages with detailed information
☐ Leave message with call- back number only

☐ Other
____

________________________________ ________________________________ __________

Parent/Guardian Signature Print Name Date

The Privacy Rule generally requires health care providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual. Healthcare entitles 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 the box if the disclosure if 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

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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

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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

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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 $300.00, Individual sessions $50.00 per half hour. ABA Evaluation $500, Individual sessions $100 per 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/ ABA 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:

____

____

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full. 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 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___________________

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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:
____
____

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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 your 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

Professional Therapy Associates, LLC

Sensory Gym and Rehabilitation Services

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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: ____________________________________