Making Waves
PEDIATRIC THERAPY CLINIC

2600 James Rd. Suite 300, Granbury, Texas 76049
Phone: 817.910.8131, Fax: 817.616.2713
www.makingwavesptc.com

Today's Date: _____

NEW CLIENT INTAKE

DEMOGRAPHIC INFORMATION

Child's Name: _____ Male [ ] Female [ ] DOB: _____

Address: _____
Street City/State Zip Code

Parent 1 Name: _____ DOB: _____

Address: _____
Street City/State Zip Code

Home Phone: _____ Cell Phone: _____

Email: _____

Occupation/Employer: _____

Parent 2 Name: _____ DOB: _____

Address: _____
Street City/State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Occupation/Employer: _____

Child lives with (Mom, Dad, Both Parents, Other): _____

Siblings (Names/Ages): _____

PHYSICIAN INFORMATION

Primary Care Physician: _____
Name Group

Phone: _____ Address: _____
Street City/State Zip Code

Other Specialist: _____
Name City Phone

MEDICAL HISTORY

Current Concerns/Reason for Referral: _____

_____

Referred by: _____

Past illnesses, injuries, hospitalizations: _____

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Current Diagnosis(es): _____

Medical precautions and/or limitations: _____

Ear infections: _____ **Tube placement** (when/which ear): _____

Medications (name, dosage, frequency): _____

_____

History of seizure disorder (type, medications): _____

Allergies (food, medication, environment, etc.): _____

Food intolerances/Dietary restrictions: _____

Behavioral difficulties (please describe): _____

_____

Does your child have a communicable disease? (i.e. Hepatitis, CMV, etc.): _____

Family history of developmental delays or learning disabilities? (yes/no) _____

_____

EDUCATIONAL HISTORY

Name of School/Preschool: _____

Teacher's Name: _____ Grade: _____

Social/Academic Strengths: _____

Social/Academic Difficulties: _____

How does your child interact with others? (cooperative, shy, friendly, aggressive): _____

_____

Does your child receive any special services at school? (please describe): _____

_____

DEVELOPMENTAL HISTORY

Pregnancy and Birth

Delivery: **vaginal** [ ] **c-section** [ ] Weeks of Gestation: _____ Birth weight: _____

Complications during pregnancy? (please explain): _____

_____

Breast-fed [ ] (how long) _____ Bottle-fed [ ] Strong suck? **yes** [ ] **no** [ ] Frequent spit-ups: **yes** [ ] **no** [ ]

How many hours does your child sleep at night? _____ Does your child take naps? **yes** [ ] **no** [ ]

Does your child wake frequently at night? **yes** [ ] **no** [ ] Temperament as a baby: [ ] Irritable [ ] Happy [ ] Quiet

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Developmental Milestones

Please note age (in months) when your child developed the following skills:

Rolled Over: _____ Sat Unsupported: _____ Belly Crawled: _____ Walked: _____ Said first words: _____

Crawled on hands & knees: _____ Combined 2-3 words: _____ Dressed Independently: _____

Tied shoes: _____ Finger fed: _____ Used spoon: _____ Drank from cup: _____

Toilet trained – Bladder: _____ Bowel: _____ Managed snaps & buttons: _____

Feeding & Oral Motor (Please complete this section if you have feeding & oral motor concerns)

Does your child demonstrate any of the following difficulties with feeding/oral motor skills:

- ❑ Overstuffing mouth with food
- ❑ Difficulties with chewing skills
- ❑ Gags/vomits during feedings
- ❑ Avoids brushing
- ❑ Frequently drools
- ❑ Avoids face washing
- ❑ Picky food preferences
- ❑ Difficulties using cup and/or

Limited diet: _____

Special diet: _____

Food texture preferences (i.e. soft, crunchy, warm, cold): _____

History of Reflux: **yes** [ ] **no** [ ] (explain): _____

Fine Motor/Sensory Processing (Please complete if you have fine motor/sensory processing concerns)

Does your child have a hand preference? ____ **Left** [ ] **Right** [ ] Does your child use scissors? **yes** [ ] **no** [ ]

Do you notice frequent grasp changes when your child holds a pencil or tool? **yes** [ ] **no** [ ]

Does your child have difficulty sitting still? **yes** [ ] **no** [ ] Does your child have frequent tantrums? **yes** [ ] **no** [ ]

Does your child have touch sensitivities? **yes** [ ] **no** [ ] Does your child appear to have weak muscles? **yes** [ ] **no** [ ]

Speech–Language (Please complete this section if you have speech-language concerns)

What is the primary language spoken in the home? _____

Does your child follow directions and respond to 1-step commands? **yes** [ ] **no** [ ]

How does your child communicate wants/needs/desires? (gestures, single words, sentences) _____

Do you feel your child can hear what you're saying? **yes** [ ] **no** [ ] _____

Does your child respond when you call his/her name? **yes** [ ] **no** [ ] _____

Do you have any concerns with your child's sound production? (difficult to understand, very few sounds, stuttering) **yes** [ ] **no** [ ]

_____

What does your child do if he/she is not understood by others? _____

Is there a family history of speech/language disorders? If so, please list: _____

_____

Additional comments: _____

_____

Gross Motor (Please complete this section if you have gross motor concerns)

Does your child have difficulty in changing positions on their own? **yes** [ ] **no** [ ]

Does your child get easily upset with being moved from one place to another? **yes** [ ] **no** [ ]

Does/did your child tolerate tummy time? **yes** [ ] **no** [ ]

Does your child get to crawl or walk up and down stairs regularly? **yes** [ ] **no** [ ]

Does your child sit upright when sliding down a slide? **yes** [ ] **no** [ ]

Does/did your child walk on his/her toes? **yes** [ ] **no** [ ]

Does your child fall frequently by tripping or bumping into things? **yes** [ ] **no** [ ]

Additional comments: _____

_____

I acknowledge the information that has been reported in this document is true and correct. I understand that failure to report comprehensive information regarding my child's medical condition(s), diagnoses, and/or developmental history may compromise his/her ability to receive the appropriate therapeutic services. As a private business, Beach Kids Therapy Center reserves the right to refuse service at any time.

Parent/Guardian Signature: _____ Date: _____

PARTICIPATION RELEASE

I (We) the undersigned parent(s) of _____, a minor, understand that participation in occupational therapy and/or speech/language therapy may involve the use of suspended equipment, climbing equipment, and/or various other active play equipment. I (We) understand that it is an integral part of my child's therapeutic process. Furthermore, I (We) the undersigned parent(s) of _____, a minor, do hereby release, discharge and hold harmless the **staff at Making Waves Pediatric Therapy Clinic** and **Making Waves Pediatric Therapy Clinic, LLC** from any and all claims and/or liability for personal injury, property damage, and claims of any nature or type arising out of my child's attendance at and participation in any therapy session.

This release is and shall be binding upon my heirs, assigns, executors, and administrators.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Printed Name of Minor Child: _____

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ATTENDENCE POLICY

Attendance Policy

- Beginning a therapy program is a big step and a real commitment. Our entire staff is committed to providing you and your family with the professional services and timely information that you will need in order to progress in your therapy goals. We also need your commitment of consistent attendance and diligent effort to make our partnership a success.
- Please have your child to therapy on time. If you leave during your child's therapy session, you must be accessible by phone and **be back 15 minutes prior to the end of the therapy session**. You will not receive verbal feedback if you are not back on time. Making Waves Pediatric Therapy Clinic does not provide childcare services and if you are late to pick up your child, you will be required to stay on site for all future therapy sessions.
- If your child's attendance falls below 70%, we will ask that you find another pediatric therapy provider who may be able to accommodate your scheduling needs.

Initial _____

MISSED APPOINTMENT POLICY

Missed Appointment/Cancellation Policy

- We understand there will be times when you will not be able to keep your appointment.
- If your child has a fever or has vomited within 24 hours of their session, we ask that you notify us and reschedule your session when your child is feeling better.
- If you must cancel a therapy session, we ask that you call us by **4:00 pm the DAY BEFORE** your scheduled appointment so we can arrange for a make-up session. This session will be scheduled with any available therapist.
- Failure to cancel by 4:00 pm the day before your scheduled appointment/s will result in a $40.00 charge per therapy session. This fee is due at your child's next scheduled session.
- To avoid the $40 charge, a make-up appointment must be scheduled within 24 hours. The appointment must be attended within one week of the missed appointment date. If the make-up appointment is canceled by you for any reason, the original $40.00 charge will be due. There are no exceptions to this policy.
- **If you do not call prior to your appointment to cancel and do not show up for your scheduled appointment, you will be charged a $75.00 no call/no show fee. There will be no exceptions to this policy and no makeups will be available.**

I have read and understand the Making Waves Pediatric Therapy Clinic Attendance and Missed Appointment Policies:

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

*some insurance carrier contracts do not allow a late/cancel fee

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INSURANCE BILLING AND FINANCIAL RESPONSIBILITY

Insurance Billing
Making Waves Pediatric Therapy Clinic is happy to file insurance claims for our in-network *and* out-of-network clients.

In-Network

- We will verify your insurance eligibility prior to your first appointment and strongly encourage you to call your member services number on your insurance card to understand your outpatient therapy benefits.
- Having therapy visits in your plan and receiving services from an in-network provider does not guarantee insurance coverage and reimbursement.
- Different insurance plans within each insurance company have different benefit limitations and exclusions.
- Many plans have therapy coverage with strict exclusions including, but not limited to, developmental delays.
- We will bill your insurance company and accept payment directly from them.
- You will initially be responsible for any deductibles, co-insurance and/or co-pays required by your plan.
- **If rendered services are denied by your insurance company for any reason, you are responsible for payment to Making Waves Pediatric Therapy Clinic for all rendered services provided.**
- Making Waves Pediatric Therapy Clinic will appeal the insurance denial on your behalf and work with you to facilitate insurance reimbursement.
- If you wish to continue services after an insurance denial has been received, you may continue as a private pay client.

Initial _____

Out-of-Network

- We will verify your insurance eligibility prior to your first appointment and strongly encourage you to also call your member services number on your insurance card to understand your outpatient therapy benefits.
- Having therapy visits in your plan does not guarantee insurance coverage and/or reimbursement.
- Different insurance plans within each insurance company have different benefit limitations and exclusions.
- Many plans have therapy coverage with strict exclusions including, but not limited to, developmental delays.
- **You are required to pay in full at the time of service.**
- We will bill your insurance company on your behalf & any reimbursements made will be sent directly to you.
- You may request an out-of-network referral to receive services at Beach Kids Therapy Center if there is not an in-network pediatric provider in you plan area.
- This will allow you to receive in-network reimbursement for an out-of-network provider.
- If rendered services are denied, Beach Kids Therapy Center can assist you with your appeal to facilitate insurance reimbursement.

Initial _____

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HEALTHCARE ELIGIBILITY WAIVER

Child's Name: _____ DOB: _____

The Patient or Patient's Legal Representative herby certifies that he/she is eligible for health plan benefits coverage, and has chosen Making Waves Pediatric Therapy Clinic as the provider of his/her health care.

Furthermore, the Patient or Patient's Legal Representative understands that if he/she is found ineligible for coverage of plan benefits, he/she is financially responsible for all costs incurred during the delivery of health services, and agrees to pay these charges to Making Waves Pediatric Therapy Clinic accordingly.

Lastly, the patient or patient's legal representative understands that he/she is also financially responsible for the cost of all non- covered, unauthorized, or services deemed to be "not medically necessary" by their insurance company. **A quote of benefits from your insurance company is not a guarantee of payment. In the event your insurance chooses not to pay for any or all rendered services provided by Making Waves Pediatric Therapy Clinic, you are ultimately responsible for all charges.**

I have been notified of the therapy benefit information provided by my insurance company. I have also been advised to contact my insurance company regarding any therapy limits and exclusions specific to my policy.

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

RESPONSIBLE PARTY AND INSURANCE INFORMATION

Individual responsible for payment: _____ Relationship to Client: _____

Address: _____
Street City/State Zip Code

Primary Insurance Carrier: _____ Provider Contact #: _____

Primary Insured: _____ Member ID #: _____

Secondary Insurance Carrier: _____ Provider Contact #: _____

Secondary Insured: _____ Member ID #: _____

Authorization to Release Medical Information

I authorize the release of any medical or other information necessary to process all claims. I also authorize payment of medical benefits either to myself or to Beach Kids Therapy Center if contracted and accepts assignment for billed services.

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

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CONSENTS & RELEASES

Child's Name: _____ DOB: _____

Acknowledgement of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand this information can and will be used to:

1) Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly,
2) Obtain payment for services, and
3) Conduct normal health care operations.

I have received, read and understand the "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that Making Waves Pediatric Therapy Clinic has the right to change its "Notice of Privacy Practices" from time to time and that I may contact MWPTC at (817)910-8131 at any time to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

Initial _____

Consent for Bathroom Release

I hereby authorize Making Waves Pediatric Therapy Clinic to allow my child to use the bathroom with staff assistance and supervision. If my child is not toilet trained, I authorize Making Waves Pediatric Therapy Clinic staff to provide diaper changing if required during the therapy session.

- ❑ I consent to my child having assistance with bowel and bladder care by Making Waves Pediatric Therapy Clinic staff.
- ❑ I do not consent to my child having assistance with bowel and bladder care. I will stay and be available to assist my child.
- ❑ My child can use the bathroom independently.

Initial _____