SCHAAL PHYSICAL THERAPY and FITNESS CENTER

PATIENT FINANCIAL POLICY

- The patient should provide active proof of insurance at the onset of therapy services. We will verify eligibility and benefits with the insurance company, but the patient should be aware that insurance coverage is between the patient and the insurance carrier and it is ultimately the patient's responsibility to know the coverage provided by their insurance policy and understand that they are financially responsible for all charges, whether or not paid by the insurance carrier.

- **Co-payments, coinsurance, and any unmet deductible, as well as payment for cash services, are to be collected at the time of service.** Cash services are those not reimbursable by insurance and include, but are not limited to, consultations, functional dry needling, and functional taping.

- If payment is fully or partially denied by the patient's insurance, it is understood that the patient will be billed directly for services rendered, though we will make every effort to obtain payment from the insurance company.

- If the patient's account becomes past due, we reserve the right to contact the individual named as emergency contact or turn the account over to a collection agency or an attorney, wherein the patient will be responsible for paying all collection/attorney costs.

- There will be a $30 fee for checks that have been returned for insufficient funds.

- We request the courtesy of 24-hour notice for cancellations or reschedules, though we do understand that, at times, circumstances are beyond one's control. If a patient no-shows three (3) times, they will be required to obtain another order for treatment from their physician in order to continue with treatment.

- The patient accepts responsibility for all costs of collection including attorney fees, collection fee of 30% and court costs.

By signing this document, the patient states that they are in agreement with the policy set forth above.

Patient Name (*printed*) : _____ Date: _____

Patient Signature: _____

Patient Data Sheet

Please complete this form in its entirety prior to your first visit. Also, please bring your insurance information and/or cards and list of medications to our office at your first visit. **It is the patient's responsibility to notify our office of any changes to your information listed on this form.**

PATIENT INFORMATION

Name:_____
Last First Middle

Address:_____
Street City State Zip

Phone: Home ( )_____ Work ( )_____ Cell ( )_____

Email: _____ Preferred way to contact you ☐Home ☐Work ☐Cell

Date of Birth:_____ Social Security Number: _____ ☐Male ☐Female

☐Married ☐Single ☐Widowed ☐Separated ☐Other

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

Employer Name/Address:_____

Emergency Contact:_____ Phone: _____
Name/Relation

THE ABOVE INFORMATION PERTAINS TO THE PATIENT ONLY

IF THE PATIENT IS A MINOR, THEN THE RESPONSIBLE PARTY COMPLETES THE NEXT SECTION.

RESPONSIBLE PARTY INFORMATION Relation to the Patient ☐Mother ☐Father ☐Other_____

Name: _____Date of Birth: _____
Last First

Address:_____
Street City State Zip

Phone: Home ( )_____ Work ( )_____ Cell ( )_____

Employer
Name/Address:_____

INSURANCE INFORMATION **ARE YOU AWARE OF YOUR BENEFITS FOR YOUR INSURANCE? ☐YES ☐NO**

Primary Insurance Name:_____ Insured Name:_____

Primary Insurance Policy #:_____ ☐SEE COPY OF CARD

Secondary Insurance Name:_____ Insured Name:_____

Secondary Insurance Policy #:_____ ☐SEE COPY OF CARD

ACCIDENT INFORMATION: Was this injury related to an accident? ☐Yes ☐No

Date of Accident/Injury:_____ ☐Motor Vehicle Accident ☐Work Related ☐Other_____

(see back side)

HIPPA: By signing this form I acknowledge that a copy of the HIPPA "Notice of Information Practices" from Schaal Physical Therapy and Fitness Center, LLC was available to me and I understand it completely. **CONSENT**: By signing this form, I agree to give my consent for Schaal Physical Therapy and Fitness Center, LLC to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

Signature _____ Date _____

SCHAAL PHYSICAL THERAPY and FITNESS CENTER

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SPEECH & LANGUAGE THERAPY INTAKE FORM

We request this information for the purpose of completing a thorough evaluation with your child. Depending on your child's abilities, some questions may not be applicable.

GENERAL INFORMATION:

Patient's Name _____ D.O.B _____ Age _____

Father's Name _____ Contact Phone # _____

Mother's Name _____ Contact Phone # _____

Person Providing Information _____ Date _____

With whom does the child live? _____

If the child has sibling/s, please list their name & age. _____

What is the primary language spoken in the home? _____

If something other than English, does the child speak the language?
____ Yes or ____ No
Understand the language? ____ Yes or ____ No
What language does your child prefer to speak? _____

Is there any known history of the following in the immediate or extended family?

___ Autism/PDD ____ADHD ____ Learning Disabilities

___ Hearing Loss ____ Stuttering ____ Speech / Language Delays

CONCERN:

When did you first have concerns about your child? _____

What made you concerned? _____

_____

What strategies or techniques have you been trying independently? _____

_____

What specific skills would you like your child to achieve in therapy? _____

_____

PREGNANCY AND BIRTH HISTORY:

Were there any illnesses, injuries, bleeding, or other complications during the pregnancy? _____

_____

Was the pregnancy full term? If not, please give gestational age. _____

Was labor and delivery normal? If no, please explain. _____

_____

What was your method of delivery (vaginal, breech, cesarean)? _____

Was oxygen or respiratory assistance required after birth? Yes/No (if yes, please explain) _____

_____

How was your child fed an infant and until what age? Bottle / Breast Age: ____

MEDICAL HISTORY:

Has your child had any of the following:

adenoidectomy
encephalitis
seizures
allergies
flu
gastroesophageal reflux (GERD)
breathing difficulties
head injury
sleeping difficulties
chicken pox
high fevers
thumb/finger sucking habit
colds
ankyloglossia
tonsillectomy
frequent ear infections
meningitis
tonsillitis How often?_____
cleft palate/lip
vision problems
ear tubes

Any other serious injuries or surgeries? (If yes, please list surgery and date)

_____

_____

Is your child currently taking any medications? (if yes, please list) _____

_____

Does your child have any known food allergies? (if yes, please list) _____

_____

Has your child's hearing been evaluated recently? (if yes, when, by whom, and what were the results?) _____

_____

Is your child presently being treated by a pediatrician? ENT? Psychologist? Therapist? Neurologist? Physical Therapist? Occupational Therapist? _____

_____

Any other precautions we should know about that are not described above?

_____

_____

DEVELOPMENTAL HISTORY:

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

_____ sat alone
_____ crawled
_____ walked
_____ fed self
_____ grasped crayon/pencil
_____ toilet trained
_____ dressed self

Does your child... choke on food or liquids? currently put toys/objects in his/her mouth? brush his/her teeth and/or allow brushing?

Does your child have difficulty walking, running, or participating in other activities that require large or small muscle coordination? If so, please describe.

Does your child have there every been any feeding problems (i.e., problems sucking, swallowing, drooling, chewing)? If so, please describe.

SPEECH/LANGUAGE DEVELOPMENT:

Was your child quiet as a baby? _____

Did your child cry excessively as a baby? _____

Did he/she coo? _____ Babble? _____

What is your child's primary mode of communication (gestures, signing, single words, short phrases, sentences, augmentative device, picture exchange)?

_____

If your child is talking, please indicate at what age your child began to:

_____ Babble _____ 2-3 word phrases _____ First Word
_____ Single words (other than "mama" or "dada")
_____ Use language as primary mode of communication

Does your child use gestures to communicate? _____

Does your child speak in complete sentences? _____

Do you think your child stutters or stammers? If yes, how often? _____

_____

Does your child answer questions? _____

Does your child follow directions? _____

How much of your child's speech do you understand?
_____ 10% or less _____ 11-25% _____ 26-50% _____ 51-75% _____ 76%+

How much of your child's speech do others understand?
_____ 10% or less _____ 11-25% _____ 26-50% _____ 51-75% _____ 76%+

Does your child demonstrate frustration when he/she is not understood?
Yes / No (Please explain) _____

Does your child...
repeat sounds, words or phrases over and over?
understand what you are saying?
retrieve/point to common objects upon request (ball, cup, shoe)?
follow simple directions ("Shut the door" or "Get your shoes")?
respond correctly to yes/no questions?
respond correctly to who/what/where/when/why questions?

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

BEHAVIORAL CHARACTERISTICS

cooperative
restless
attentive
poor eye contact
willing to try new activities
easily distracted/short attention
plays alone for reasonable length of time
destructive /aggressive
separation difficulties
withdrawn
easily frustrated/impulsive
inappropriate behavior
stubborn
self-abusive behavior

PLAY AND SOCIAL SKILLS

Does your child engage in eye contact during communication?
Yes / No / Sometimes

When given a choice, does your child prefer to play alone or with others?
Alone / Others

How does your child interact with others (shy, aggressive, cooperative, etc.)?

What are some of your child's favorite toys/interests? _____

_____

_____

Does your child:

Answer questions logically? Yes / No / Sometimes
Greet people arriving or leaving? Yes / No / Sometimes
Engage in turn taking? Yes / No / Sometimes
Initiate conversation? Yes / No / Sometimes
Maintain a topic? Yes / No / Sometimes
Recall & tell about everyday events? Yes / No / Sometimes
Follow one-step directions? Yes / No / Sometimes

EDUCATION

Does your child attend school? If yes, where and how often? _____

_____

What grade is your child presently in? _____

Please list any services your child receives at school (speech, occupational therapy, physical therapy, tutoring, etc.). _____

_____

Does your child experience any specific challenges in school? (Please explain)

_____

_____

May we communicate with the school therapists to collaborate services?
Yes / No (If yes, please list their information on the "Consent for Release" form and provide a copy of your child's most current IEP)

COGNITIVE DEVELOPMENT

Does your child play with any toys now? If so, what? _____

_____

Does your child seem to learn quickly? Slowly? Is he/she an average learner?

_____

How would you describe your child as the best way he/she learns/studies?

_____

Does your child have difficulty solving everyday problems? Provide an example if possible: _____

_____

_____

Reasoning? If so, explain: _____

_____

Does your child have difficulty following muti-step directions?_____

_____

READING AND WRITING (IF AGE APPROPRIATE PLEASE COMPLETE)

Has your child had any problems learning to read? Learning to write? Explain:

_____

_____

_____

Do you/Did you read to your child? _____

Does/did your child enjoy being read to? _____

What does your child enjoy reading? Dislike reading? _____

_____

Does your child know the alphabet? _____

Does your child have difficulty learning/using new words? Explain: _____

_____

_____

_____

Does your child have difficulty learning/retaining new information Explain: _____

_____

_____

_____

Can your child write well for his/her age? _____

Thank you for taking the time to complete this form.

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CHILD'S NAME _____ DATE _____

PLEASE LIST YOUR CHILD'S FAVORITE...

FOOD _____
SPORT/TEAM _____
SNACK/CANDY _____
SONG _____
BOOKS _____
MOVIE _____
TOY OR STUFFED ANIMAL _____
CARTOON CHARACTER _____
GAME _____
INSIDE ACTIVITY _____
OUTSIDE ACTIVITY _____
SCHOOL SUBJECT _____
TV SHOWS _____

MY CHILD IS AFRAID OF:

_____

WHEN MY CHILD HAS FREE TIME, HE/SHE IS USUALLY...

_____

THREE WORDS THAT BEST DESCRIBE YOUR CHILD

_____

WHAT DOES YOUR CHILD WANT TO BE WHEN HE/SHE GROWS UP?

_____

PARENT COMPLETED INTEREST INVENTORY

IF MY CHILD HAS TROUBLE FALLING ASLEEP I USUALLY...

WHAT KINDS OF THINGS DOES YOU CHILD LIKE TO LEARN ABOUT?

WHAT MOTIVATES YOUR CHILD?

OTHER PEOPLE WHO HAVE REGULAR CONTACT AND ARE INVOLVED WITH MY CHILD'S CARE (GRANDPARENTS, STEP PARENTS, SIBLINGS, FRIENDS, ETC.)...

NAME _____ RELATIONSHIP _____
NAME _____ RELATIONSHIP _____
NAME _____ RELATIONSHIP _____
NAME _____ RELATIONSHIP _____

ANYTHING ELSE YOU WOULD LIKE TO SHARE ABOUT YOUR CHILD TO HELP HIM/HER FEEL MORE COMFORTABLE (ESPECIALLY IN THE FIRST WEEK WHEN WE ARE BRAND NEW TO EACH OTHER)...