therapy works

CASE HISTORY FORM

IDENTIFYING AND FAMILY INFORMATION:

Child's Name: _____ Birthdate_____

Father's Name: _____ Daytime Phone: _____

Address: _____

City, State Zip: _____ Cell Phone: _____

Mother's Name: _____ Daytime Phone: _____

Address: _____

City, State Zip: _____ Cell Phone: _____

Email_____

Physician's Name: _____ Clinic: _____

Doctor's Phone: _____

Child Lives with (check one): ____Birth Parents ____Parent and Step Parent ____Adoptive Parents ____One Parent ____Foster Parents ____Other: _____

Is there a language other than English spoken in the home? _____Yes _____No. What Language_____

Does the child speak the language? _____Yes _____No Language Preference: _____

Birth History: Weeks Gestation_____Delivery method_____ Complications_____

Is your child currently (or recently) under a physician's care? _____Yes _____No If yes, why?

_____

_____

Please list any medications:_____

BEHAVIOR CHARACTERISTICS:

_____ cooperative _____ restless _____ attentive _____ poor eye contact _____ willing to try new activities _____ destructive/aggressive _____ plays alone for reasonable length of time _____easily distracted/short attention span _____ separation difficulties _____ withdrawn _____ easily frustrated/impulsive _____ inappropriate behavior _____ stubborn _____ self-abusive behavior _____ particular about clothing textures _____ texture avoidance _____ crashing

SCHOOL HISTORY:

Name of school and grade in school: _____

Has your child repeated a grade ? _____Is an IEP in place?_____

What are your child's strengths and weaknesses in school? Are they receiving help?_____

_____

_____

MEDICAL HISTORY	AGE	DEVELOPMENTAL HISTORY	AGE
ALLERGIES	o	SITTING	o
ASTHMA	o	CRAWLING	o
CHRONIC ILLNESSES	o	STANDING	o
DIFFICULTY EATING	o	WALKING	o
DIFFICULTY SLEEPING	o	RUNNING	o
EAR INFECTIONS	o	TOLIET TRAINED	o
HEARING DIFFICULTIES	o	LIKES BATH	o
HEARING AIDS	o	DRESSES SELF	o
REFLUX	o	FEEDS SELF	o
TUBES	o	BRUSHING HAIR	o
VISION DIFFICULTIES	o	BRUSHING TEETH	o
SEIZURES/CONVULSIONS	o	STARTED BABBLING	o
STOMACH DISORDERS	o	USING WORDS	o
INJURIES	o	COMBINING WORDS	o
HOPITALIZATIONS	o	PRONOUNCING WORDS CORRECTLY	o
SURGERIES	o	# OF WORDS	o
ASSISTIVE DEVICES	o	STUTTERING	o
ACTIVITIES		VOICE CONCERNS	o
COLORING	o	DIFFICULTY SWALLOWING	o
WRITING		GAGS	o
SITTING IN CHAIR	o	CHOKES	o
PLAYING WITH TOYS	o	TEXTURE ADVERSITY	o
CLUMSY	o	DRINKS FROM CUP	o
TROUBLE WITH BALANCE	o	SENSATION OF FOOD STUCK IN THROAT	o
DIFFICULTY WITH STAIRS		**CONDTIONS**	
OVERALL WEAKNESS	o	OVERLY SENSITIVE TO TOUCH	o
HAND PREFERENCES	o	FEAR ANYTHING	o
OTHER:	o	SENSITIVE TO CERTAIN SOUNDS	o
		NOT HEAR CERTAIN SOUNDS	o
FAMILY HISTORY:	o	REFUSES TO WEAR CERTAIN CLOTHING	o
DIFFICULTY MAINTAINING EYE CONTACT	o	OUTBURSTS	o
CLOSE ONE EYE TO LOOK AT SOMETHING	o	OVERLY DISLIKE FACE WASHING	o
TIP HEAD TO LOOK AT SOMETHING	o	OVERLY DISLIKE BRUSHING	o

therapy works

Attendance Policy

Thank you for choosing Therapy Works of Wilmington, LLC. We want to provide the best possible services to all of our patients. We will do our best to schedule appointments that meet your needs. Regular attendance is important to your/your child's success. We ask that you follow the attendance policies outlined below:

1. **Cancellations:** Please call us at least 24 hours in advance to cancel your appointment.
2. **Missed Appointments:** If you cancel or do not attend 3 sessions in a row, we will put your services on hold until scheduling problems can be worked out.
3. **Late for Appointments:** If you are more than 20 minutes late for your appointment, we reserve the right to cancel the appointment and consider it a missed appointment (see policy for missed appointments above). If you are late for 3 or more sessions, we may put your services on hold until scheduling problems can be worked out.
4. **Clinician Cancellations:** If your therapist is not able to attend your appointment, you will be contacted as soon as possible. Please be sure that our office knows the best way to reach you. Every effort will be made to reschedule your appointment in a timely manner.

Payment Policy: Insurance Billing

Thank you for choosing Therapy Works for your Therapy needs. This is an agreement between Therapy Works and you for payment of services provided. By signing this agreement, you are agreeing to pay for all services provided to you or your family member.

Please read the following information carefully.

If you want Therapy Works to bill your insurance for evaluations and treatment, you need to:

- Bring your insurance card and information to your evaluation.
- Let the office know if your insurance changes.
- Check with your insurance company before your first visit to find out what therapy services they will pay for.
- Pay all co-pays, deductibles, and non-covered services.
  - We will submit a claim to your insurance company.
  - If your insurance will not pay for services you will be responsible for paying the full amount.
  - If your insurance company does not pay us within 45 days, you will be billed for the full amount. If we get paid by the insurance company after that, we will return your payment.*
- Pay any money owed within 15 days of receiving a bill from our office.

If you do not have insurance:

- Payment is due at the time of service. We accept cash, checks, cashier's checks, or major credit cards.

Or

- You will be billed for services at the end of each month. Payment is due within 15 days of receiving our bill.
- We are happy to talk about other payment arrangements, if needed. Talk to us ahead of time to make payment arrangements. Please don't wait until you are not able to pay to talk with us.

Returned checks:

- You will be charged a $35 fee for each returned check.
- You will be asked to bring cash in to the office to cover the amount of the returned check and the fee.

Assistant/Supervising Clinician

You are aware that your child may receive therapy from an SLPA and/or a COTA. All treatment will be supervised by a board certified Occupational Therapist and/or Speech Pathologist.

Photo/Video Release

I hereby give my consent to THERAPY WORKS OF WILMINGTON,LLC, to photograph, film, videotape, and then use, reproduce, and publish said images of me and/or my child listed above. I agree that photographs, film, or videotapes thereof shall constitute the sole property of THERAPY WORKS OF WILMINGTON,LLC with full right of disposition in any manner whatsoever. I hereby release THERAPY WORKS OF WILMINGTON,LLC and their legal representatives and assigns from any and all claims whatsoever in connection with the use, reproduction, and/or publication of the images thereof for marketing their services

Acknowledgment That You Have Received Our HIPAA Privacy Notice

Therapy Works is required by law to keep your health information safe. This information may include:

- notes from your doctor, teacher, or other health care provider
- your medical history
- your test results
- treatment notes
- insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared. It also tells you how you can look at and comment on your information.

In signing this document, you are aware and understand our attendance policy, billing procedures, use of assistants, gym liability wavier, photo release, and HIPAA guidelines and receipt.

Print Patient's Name _____ Date _____

Patient or Parent/Guardian Signature _____

Relationship to Patient _____

therapy works

Liability Wavier/Developmental Gym

I, _____ (Print Full Name), am the parent/legal guardian of the Child(ren) named below or I have obtained permission from the parent/legal guardian of the Child(ren) named below to sign this agreement on their behalf.

I give permission and accept full responsibility for the Child(ren) to participate in the activities at THERAPY WORKS OF WILMINGTON,LLC. As a Condition to the Child(ren)'s participation in the activities and by signing this form, I acknowledge and agree that:

* The operator(s) of this facility have advised me of the proper use and possible hazards of the activities.
* The Child/Children and I are solely responsible for deciding whether or not to participate or to rely upon any instructions, advice, or information regarding the activities
* It is not THERAPY WORKS OF WILMINGTON, LLC's purpose to teach safety before, during or after participation and use of the structures/equipment.
* I am solely responsible for the decision to allow the Child to participate and use the structures/ equipment.
* I am of legal age and mental competence to knowingly give this acknowledgement and release, which shall legally bind me and the Child(ren) and our personal representatives, executors, heirs, and assigns.

I HERBEY RELEASE AND WAIVE, ANY AND ALL CLAIMS , KNOWN AND UNKNOWN, THAT THE CHILD/CHILDREN OR I MAY NOW OR LATER HAVE AGAINST THERAPY WORKS OF WILMINGTON,LLC, ITS MEMBER(S), OFFICER(S), INSTRUCTOR(S), OPERATOR(S) AGENTS, OR REPRESENTATIVES RELATED TO ANY ACT, OMISSION, STATEMENT, OR OCCURRENCE DURING OR RELATED TO THE USE OF THE STRUCTURES/ EQUIPMENT OR THE FACILITY, FOR , LIABILITY FOR DIRECT, INDIRECT, VICARIOUS, PUNITIVE AND ANY OTHER DAMAGE WHETHER SUCH PARTY WAS INFORMED OR WAS AWARE OF THE POSSIBILITY OF SUCH LOSS OR DAMAGE.

_____ _____ _____

Child's Name (Print) Date of Birth Child's Name (Print) Date of Birth

_____ _____ _____ _____

Child's Name (Print) Date of Birth Child's Name (Print) Date of Birth

_____

Parent/Guardian Signature Date

Phone_____ Zip_____Email _____

By providing your e-mail address, you acknowledge subscribing to our e-mails including discount offers, special events, and Kids Blvd news.

Photo/Video Release

I hereby give my consent to THERAPY WORKS OF WILMINGTON,LLC, to photograph, film, videotape, and then use, reproduce, and publish said images of me and/or my child listed above. I agree that photographs, film, or videotapes thereof shall constitute the sole property of THERAPY WORKS OF WILMINGTON,LLC with full right of disposition in any manner whatsoever. I hereby release THERAPY WORKS OF WILMINGTON,LLC and their legal representatives and assigns from any and all claims whatsoever in connection with the use, reproduction, and/or publication of the images thereof for marketing their services only and not for sale of images.

_____

Parent/Guardian Signature Date

***Please be aware that it is REQUIRED for all children to wear socks while they are in**

therapy works

Authorization for Release of Information

I give Therapy Works permission to use or share my health information with: (Please all that apply)

My Physician School CDSA Other _____

The information that will be used or shared includes (check all that apply):

- ☐ My medical records
- ☐ My treatment records (progress notes, daily records)
- ☐ My evaluation results
- ☐ Other: _____

I understand that:

- I do not have to sign this authorization. I will still be able to get treatment here even if I do not sign it.
- I am allowed to see or copy the health information that will be used or shared.
- I can take back this authorization at any time. I need to write to Amy Nolan at 4114 Shipyard Blvd, Wilmington, NC 28403 to request to do this.
- Any information that was used or shared before I took back the authorization cannot be returned.
- The person or organization that gets my health information because of this authorization may have the right to share it with others without my permission.

_____ _____

Print Patient's Name Date

_____ _____

Patient or Parent/Guardian Signature Relationship to Patient