Children's
Therapy Network LLC

Welcome!

Thank you for your interest in services through Children's Therapy Network. Enclosed is our intake packet. Please look through this paperwork carefully and complete as fully as possible. If you have questions or would like clarification, please do not hesitate to contact our office further.

While it is very helpful to the therapist to receive the completed intake packet prior to seeing your child, please also note we will need a copy of your insurance card and a prescription for occupational, speech and language, physical therapy, or mental health services (if applicable) at the time of your initial evaluation. Failure to complete the packet may delay services until we can ensure that the required information is obtained.

If you need directions, please refer to our website, www.ctn-madison.com, or call our office at 608-234-5990.

We are excited to get to know you and your family!

Kindest Regards,

Jennifer Bluske Krull
Occupational Therapist and Owner
jen.bluske@ctn-madison.com

CHILD REGISTRATION

Date: _____

Child's name: _____ Date of birth: _____ Sex: _____

Preferred Gender:_____ Address: _____City:_____State:_____

Zip code: _____ Home phone: _____

Guardian #1:_____

Address: _____

City, State, Zip code: _____

Cell phone: _____

Work phone: _____

E-mail: _____

Date of birth: _____

Occupation: _____

Employer: _____

Guardian #2:_____

Address: _____

City, State, Zip code: _____

Cell phone: _____

Work phone: _____

E-mail: _____

Date of birth: _____

Occupation: _____

Employer: _____

EMERGENCY CONTACT/MEDICAL RELEASE

In the event of a medical emergency in which the parent is unable to be reached, please contact the following:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I authorize medical treatment delivered for medical emergency in the event I am unable to be reached

Signature: _____ Date: _____

BILLING INFORMATION

Responsible Party: _____

☐ I will be paying privately for services at CTN ☐ I understand that CTN is not an MA provider

PRIMARY INSURANCE

Insurance company: _____

Policy #:
Group #:
Policy holder:
Policy holder DOB:
Policy holder employer:
Relationship to client:
Telephone # (insurance company):

SECONDARY INSURANCE

Insurance company: _____

Policy #:
Group #:
Policy holder:
Policy holder DOB:
Policy holder employer:
Relationship to client:
Telephone # (insurance company):

PHYSICIAN INFORMATION

Referring physician:	
Hospital or Clinic:	
Phone number:	
Fax number:	
Address:	
City, State, Zip code:	

MEDICATION INFORMATION

Medication name(s):	
Medication purpose(s):	
Dosage(s):	
Prescribing doctor:	
Comments:	

CHILD HISTORY

EARLY DEVELOPMENTAL HISTORY

Please describe your child's birth history, describing any complications during pregnancy, birth or infancy.

To the best of your recollection when did your child meet the following milestones:

Sitting: _____ Crawling: _____

Walking: _____ Speak first words: _____

Potty training: _____ Speak sentences: _____

Please describe any concerns that you had regarding your child's early development.

Please describe your child's living situation. Please include who lives in the home with your child and other important people in the child's day.

MEDICAL HISTORY

Does your child have a history of illness such as frequent ear infections, viral illness, or respiratory problems or major illnesses requiring hospitalization? Please describe.

Does your child have any precautions we should know about such as allergies, seizures, special diets? Please describe how you would like the above mentioned managed.

Has your child's hearing and vision been assessed? If so, what were the outcomes?

Does your child have a diagnosed condition that you would like to share with us? If so, when was this diagnosis received and by whom was the diagnosis made?

We are interested in prior and current other services and treatments that your child was/is receiving**. It is very helpful to have pertinent reports available for review prior to the evaluation.** Please list the service provider, approximate the dates service was provided, and the duration of treatment.

Professional Type:	**Name(s):**	**Contact Information:**	**Permission to Release Information?**
Pediatrician or Primary Physician and Clinic			☐Yes ☐No
Specialty Physician and Clinic (psychologist, neurologist, etc.)			☐Yes ☐No
Specialty Physician and Clinic (psychologist, neurologist, etc.)			☐Yes ☐No
Mental Health/Behavioral Therapist and Clinic			☐Yes ☐No
OT/PT/SLP Therapist and Clinic			☐Yes ☐No
School/Daycare name (Educational/Therapy staff, IEP Team)			☐Yes ☐No
In-Home Autism Provider			☐Yes ☐No
Birth to Three Provider			☐Yes ☐No
In-Home Personal Aide			☐Yes ☐No
Other			☐Yes ☐No

Child's school district: _____ Grade: _____

Does your child have an IEP: ☐ Yes ☐ No **If yes, please attach a copy to the paperwork.**

SOCIAL DEVELOPMENT

Number of regular playmates:	Age(s):	Sex or Preferred Gender(s):

What activities will your child share with siblings and parents?

BEHAVIOR CHARACTERISTICS

Generally my child is:

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

How does your child handle frustration and conflict?

What are your child's favorite:

places: _____ people: _____

activities: _____ snacks: _____

toys: _____ TV programs/movies: _____

Are there any extreme dislikes and/or fears your child has?

What motivates your child the most?

What discipline methods work best?

DAILY ROUTINES

Please describe toileting skills. Please include occurrence of daytime and nighttime accidents and awareness of toileting need.

Please describe your child's eating habits. If your child is a picky eater, please include the foods that they will eat.

Please describe how your child transitions between people and environments. Please include what strategies that you have found helpful.

Please describe your child's typical routines:

Wake-up routine: _____
_____
_____

Bed-time routine: _____
_____
_____

During the night: _____
_____
_____

Does your child seem irritable during predictable times of day? If yes, please describe what seems to trigger the irritability.

PARENT FEEDBACK

What are areas of concern for your child?

Please describe your child's strengths (ie: positive personality traits, talents, interests)

What do you currently find to be the most rewarding part of caring for your child?

What do you currently find to be the most challenging part of caring for your child?

What do you hope to get out of therapy for you and your child?

Is there anything that would be helpful to know about your child prior to their evaluation?

How did you find out about us?

Children's Therapy Network LLC

POLICY AND FEE AGREEMENT

Client Name: _____ Parent/Guardian Name(s): _____

The following is a description of Children's Therapy Network, LLC's policies. Please read and indicate your agreement to abide by these policies by initialing and signing where indicated. If you have any questions about these policies, please ask a clinic staff member before signing.

SCHEDULING POLICIES

1. I understand that a treatment session consists of 50 minutes of direct treatment. An additional 10 minutes is used for parent consultation, set-up, clean-up and transitions into and out of the treatment space. _____***initials***

2. I understand that in order to receive the maximum benefit from treatment, it is important for Treatment to occur at the treatment frequency determined between the therapist and family. I understand that notification of vacation or family obligation is requested **at least two weeks** prior to the expected absence, to facilitate rescheduling our appointment. I understand that we may schedule make-up sessions for vacation times, if there are times available. _____***initials***
3. I understand that for sessions cancelled with less than 48 hours notice (unless the child becomes ill in the morning); a cancellation fee of $55.00 will be charged and is billed directly to me. I understand that if sessions are cancelled with more than 48 hours notice, I will not be charged a cancellation fee; however, this clinic encourages scheduling a make up for these and all other sessions in order to ensure optimal progress. If I cancel within less than the 48-hour period, but schedule and attend a make up session, the cancellation fee will be waived. _____***initials***
4. I understand that if we do not cancel and do not keep a scheduled apt. **(NO SHOW),** we will be charged the full fee for the session of $110.00, and the session cannot be made up. I also understand that **three no shows will result in the termination of our treatment slot**. _____***initials***
5. I understand that if my child was not well enough to attend school on the day of his/her appointment that I should not bring them to their scheduled therapy session that afternoon. I also understand that if my child attends therapy, and then comes down with an infectious illness or condition such as strep throat, conjunctivitis, chicken pox, lice, etc. I should notify the clinic immediately so that other children in the area that day can be notified. _____***initials***
6. I understand that the snow day policy is as follows: the clinic is open except in cases of severe conditions requiring businesses to close. Any cancellations due to weather will be left on a recorded message on the voicemail system. Families may cancel treatment if they do not wish to travel because of poor road conditions. I understand that snow day cancellations will not be charged a cancellation fee. _____***initials***

Children's Therapy Network LLC

FINANCIAL POLICIES

1. I understand that Children's Therapy Network, LLC cannot wait for payment and that my **co-payments or private payment is due the day of service**. Payments can be placed in the drop box, or we are able to accept credit card payments (Visa or MasterCard) for services. A receipt for payment will be mailed to you monthly. _____ ***initials***

2. I understand that CTN is not an MA provider _____***initials***

3. My monthly co insurance balance must be paid by the due date. _____***initials***

4. If my account becomes overdue by 30 days, I understand that Children's Therapy Network, LLC, will discontinue therapy until payment is made. _____***initials***

5. I understand that this clinic may bill my insurance companies directly at my request only when all of the proper Insurance information is on record in the office. It is my responsibility to contact my insurance plan to find out exactly what is required for direct billing. _____***initials***

6. I understand that my amounts not covered by my insurance, including deductibles, coinsurance in addition, non-reimbursable items (such as reports, consultation, and travel) must be paid by the due date or treatment will be discontinued. I also understand that submission of claims to the insurance company does not guarantee payment and that I will be held responsible for all amounts billed. _____***initials***

7. I have initiated services and understand that, if I am paying privately, the treatment fee is due on the day of our scheduled appointment. I will be billed at the beginning of each month for extraneous services provided the previous month. The bill must be paid within 15 days after the bill is issued. All checks are to be made payable to *Children's Therapy Network, LLC*. If an insurance carrier has authorized direct billing, I understand that my bill will reflect only that amount not covered or authorized, which is due for me. _____***initials***

8. I understand that if a claim submitted directly by this clinic to my insurance company is not paid within 60 days of submission, the balance becomes due immediately from me. The Children's Therapy Network, LLC, therapist will assist in obtaining insurance coverage by writing reports and letters to insurance companies. _____***initials***

9. I understand the need to provide notification of outside meeting or consultations at least three weeks in advance to allow our therapist to prepare and to coordinate meeting dates and times. I understand that if I want my Children's Therapy Network, LLC therapist to attend an outside meeting (IEP, Team meeting, etc.) I will be billed the hourly consult rate plus travel time to and from the appointment. _____***initials***

10. I have read the above information and understand that, as a client, parent, or guardian, I am ultimately responsible for payment of all services provided by Children's Therapy Network, LLC. In the event that my insurance company or other source of payment decreases or discontinues payment for services for any reason, I will be responsible for assuming payment for past, current, and future services. _____***initials***

Children's Therapy Network LLC

OFFICE POLICIES FOR FAMILIES

Whenever possible and at the request of the therapist, I will be an active part of the therapy sessions with my child. I understand that therapy at Children's Therapy Network, LLC, is as much about teaching the parent strategies and supports as it is about engaging the child. I understand that as a parent or caregiver, I am part of the therapy team and all input and ideas are warranted and welcomed within the session. _____***initials***

I understand that siblings often need to attend sessions with their family. I will work with the therapist to determine if it would be most beneficial for the parent/sibling to wait in the waiting room during the session, or if the family should come into the session with the client. At all times, I am responsible for the other siblings in the treatment space to ensure their safety and that they are not interfering with the treatment of other clients in the treatment space. _____***initials***

ACKNOWLEDGEMENT OF RISK

I acknowledge that there is some risk inherent in the use of the therapy equipment at this clinic, and I agree to indemnify and hold Children's Therapy Network, LLC, harmless from any and all losses and claims for any injuries or other damages occurring to myself or my child or our belongings from the use of therapeutic equipment. _____***initials***

I have read and agree to abide by the above policies.

Signature: _____ Date: _____

OPTIONAL POLICIES

Each of the following policies may be initialed or left blank. If you do not wish to sign any one of the following, your therapist may approach you for permission in the event that a need for any of the unsigned items occurs.

TEACHING AND RESEARCH ACTIVITIES

I give permission for occupational therapy students to observe my child's therapy. I understand I will be notified prior to each observation. _____***initials***

I give permission for photographs/videotapes to be taken of my child for educational and/or promotional purposes. I understand that any such recordings or photographs will be reviewed by me prior to release. _____***initials***

I hereby authorize Children's Therapy Network, LLC to furnish information to insurance carriers and I authorize insurance benefits to be made to myself or on my behalf to Children's Therapy Network, LLC for services rendered to my dependents or me. All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. **However, the patient is responsible for all fees regardless of insurance coverage. I further understand that insurance coverage does not guarantee payment of services and that the patient/guardian/caregiver is responsible for payment of all fees owed to Children's Therapy Network, LLC. Non-payment for services rendered will result in discontinuation of services.**

Signature: _____ Date: _____

Children's Therapy Network LLC

HIPPA PRIVACY AUTHORIZATION FOR USE

AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

-This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

-This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

-Children's Therapy Network, LLC ("Covered Entity") will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. *YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.*

-By signing this authorization you acknowledge and agree that Covered Entity may use or disclose treatment paperwork for the purpose(s) of guiding treatment.

-By signing this authorization you agree that Covered Entity or its Business Associates may disclose your personal health care information to: required insurance agencies for recouping payment and state agencies as necessary under the requirements for mandated reporters.

-Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at any of its offices or by sending a written request with return address to: 14 Ellis Potter Court, Suite 200 Madison, WI 53711.

-In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

-You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

-This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity, or (d) six years from the date this authorization was executed.

-By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA. Covered Entity will provide patient with a copy of this signed authorization.

Acknowledged and agreed to by:

Patient

Print name: _____
Signature: _____
Date: _____

Parent/Guardian (on behalf of patient)

Client name: _____
Signature: _____
Date: _____