Sensory Playground Pediatric Therapy Center

Client Information

Name (First, MI, Last): ________________________________ Name Child Goes By:__________

DOB: _____________ Sex: M/F SSN: _______________ Referred By:_____________________

Parent Information

Mother: Name (First, MI, Last): ________________________________ DOB:__________

SSN:_________________ If NOT Biological Mother, Indicate Relationship:__________________

Cell Phone: _______________ Home Phone: _______________ Email:____________________

Address:______________________________ City: _____________ State:______ Zip:_________

Employer:____________________ Position: ___________________ Work Phone:___________

Father: Name (First, MI, Last): ________________________________ DOB:______________

SSN:_________________ If NOT Biological father, Indicate Relationship:__________________

Cell Phone: _______________ Home Phone: _______________ Email:____________________

Address:______________________________ City: _____________ State:______ Zip:_________

Employer:____________________ Position: ___________________ Work Phone:___________

Insurance Information

Primary Insurance Company:________________________

Policy holder:_______________________ Relationship to Client:____________

Policy #:______________________ Group#:_______________________

Secondary Insurance Company:________________________

Policy holder:_______________________ Relationship to Client:____________

Policy #:______________________ Group#:_______________________

Party responsible for payment: Mother____ Father_____ Other (Fill out below)____

Name:__________________ Phone #: ____________ Address:___________________________

Emergency Contact (not living in household):

Name: _______________________ Phone #:_____________ Relationship to client:__________

PT/OT Health History

Diagnosis(es): ____

Chief Concerns/Symptoms: ____

Birth Information: Full Term ____ Premature____ Gestational weeks_____ Birth Weight _______

Vaginal___ C-Section ___ Complications (NICU, Oxygen, etc.):______________________________

Surgeries/ hospitalizations (purpose, dates):____

Assistive Devices: ____

Allergies: ____

Medications: ____

Primary Care Physician:_____________________________________ Phone #:_________________

Other Doctors and Their Specialties: ____

____

Health Items	Check	Age	Explanation
Seizures			
Fainting			
Asthma			
Brain Injury			
Heart Disorder			
Stomach/Intestinal disorders/reflux			
Ear Infections/ Tubes			
Hearing Difficulties			
Vision Difficulties			
Difficulty Sleeping			
Difficulty Eating			

Family History Items	Check	Age	Explanation
Learning Disorders			
Emotional Disorders			
Genetic Disorders			
Attention Disorders			
Speech/ Language Disorders			
Substance Abuse			

Privacy Policy

Patient Name: _____________________

Sensory Playground follows the guidelines below when addressing the privacy of your records at this facility.

- Only questions pertinent to your services are asked.
- You have the right to refuse to answer questions.
- You have the right to request access to your personal records, evaluation reports, and progress reports.
- If you believe the information in your file is in error you have a right to request an addendum.
- Information is not shared physically or electronically, with any other agency or facility without your signed permission.
- Information shared with any personnel is kept in confidence, in accordance with HIPPA.
- It is your right to talk about your child in the privacy of our office or clinic room.

I have read this policy and had the opportunity to ask questions:

____ _________________

Signature (Specify relationship if child is a minor) Date

____

Print name

Authorization to Release Information

Patient Name: _____________________

I hereby authorize Sensory Playground Therapy Center to release information concerning therapy evaluations and treatments of the above named patient to the following person(s) or agencies:

Name/ Agency:____
Adress:____

This authorization can be revoked at any time upon written request, except to the extent that action has already been taken. All information will be considered confidential.

____ ________________
Signature (Specify relationship if child is a minor) Date

____
Print name

Permission for Media Use

Patient Name: ______________________________ DOB:_______________

With permission, Sensory Playground Therapy Center will occasionally take photos or videos of a client during therapy sessions for use within our facility (brochures, newsletters), maintaining our social media presence, and for educational purposes.

I understand that photos or videos of my child may be used in brochures, newsletters, etc. and authorize such use.

____ _________________

Signature (Specify relationship if child is a minor) Date

____

Print name

I would not like my child's picture taken at this time: _______________

Parent's Initials

Billing and Insurance Policies

Patient Name: _____________________

For our who have insurance plans that Sensory Playground Therapy Center does not participate with, payment is due at the time of the visit.

Insurance Cards: Insurance companies have many different plans, some have a deductible, which is the patient's responsibility. Some require authorization or referral for visits and others do not. It is the patient's or parent's responsibility to check their specific coverage before your visit so that you will understand your coverage.

Copays: If your insurance company requires a copay (usually listed on your card), this payment is requested at check-in time prior to the visit. We have a fee for use of a credit card.

Referrals: If a referral is required by your insurance, it is the patient or parent's responsibility to get a referral from the primary care doctor prior to the visit. This will make you responsible for the visit's fee if your primary care does not send a referral.

Two Insurances: if you have coverage by two insurance plans, we need to know which is Primary and which is Secondary. We also need to know who the subscriber for each policy is, the employer of each subscriber, and their birthdays.

I understand that I am solely responsible, if my insurance company does not cover my visit.
I have read the above information and have had the opportunity to ask questions.

_______________________________________ _______________

Signature (Specify relationship if child is a minor) Date

____

Print name

Attendance Policy

Patient Name: ______________________

The purpose of the Sensory Playground is to provide Occupational Therapy, Physical Therapy, and Social Group Therapy to those individuals for which it is recommended.

It is expected that patients enrolled in therapy will attend ALL scheduled sessions and will participate in the program planned for him/her. **If a patient does not show up for the appointment and does not provide 24-hour notice, there will be a $25 charge to the account.**

As we have an extensive waitlist, if a patient misses two (2) consecutive sessions without an acceptable excuse, or without notifying the Clinic Personnel, he/she will be dismissed from therapy.

Readmission will be made only upon request by the patient to the Clinic Director.

I have read the above policy and accept these conditions.

____ ________________

Signature (Specify relationship if child is a minor) Date

____

Print name