East Orlando Office
12301 Lake Underhill Rd
Suite #260
Orlando, FL 32828

(407)-249-3344 Office
(407) 378-2978 Fax

Hunter's Creek Office
13574 Village Park Dr.
Suite #240
Orlando, FL 32837

Dear Parent(s):

Welcome to Therapy Essentials Inc Corp. We are so pleased that you have chosen us for your child's speech therapy needs. Be assured that every effort will be made to insure that their experience is both a productive and a pleasant one. Our goal is to help your child achieve his/her fullest potential.

There are a few things that we will need to obtain from you before or at the first scheduled visit. Attached you will find a "Patient Information Packet". Each sheet is very important, and therefore we ask that you read them carefully and complete them as accurately as possible. If there is a portion that does not apply, simply enter "NA". Please review the items listed below, and be sure that we have the items that apply in our office by your initial visit.

Therapy cannot begin unless we have all of the following on file:

- Patient Information sheet
- Medical Case History sheet
- **ORIGINAL RX** (required from physician if filing with Insurance or Medicaid). This is required to Document medical necessity. It is independent of any additional requirements for a referral or authorizations that your insurance might require.
- Copy of insurance card (front and back) (if applicable.
- Copy of Medicaid card (if applicable)
- *Signed* Consent to treat form (attached)
- *Signed* Cancellation Policy (attached)
- IEP (school) or IFSP

We will be happy to bill your insurance company for you; however, **you are responsible for contacting your insurance company prior to your first visit in order to determine your benefits for speech therapy**. Any unpaid balances become your responsibility.
The attached *Insurance Billing Information*, *Privacy Policy* statement, as well as our *Driving Instructions* are included for your information only and DO NOT need to be returned to us.

Please contact us at (407) 249-3344 if you have any questions.
Sincerely,
The Staff at Therapy Essentials Inc.

Patient Information

Name: _____
Male _____ Female _____ Date of Birth: _____
Street Address
_____
City _____ Zip _____Home phone_____

Parent/Guardian Name _____ _____ Cell Ph. _____
Email _____ Work Ph._____

Referring Physician:
_____

Clinic Name: _____ Phone: _____
Clinic Address:
_____

Reason for Referral:
_____

Diagnostic code (if known)
_____

Funding Information: Check those that apply and provide copy of insurance card.
___ Private Pay

___ Medicaid ID: _____

Prior Evaluation Date *(if applicable)*:_____

___ Insurance Company Name: _____

____ HMO ____ POS ____ PPO _____ Other (specify) _____

Insured's Name: _____

Insured's DOB:_____

Member ID#: _____Group#: _____

Insured's Address (if different from above):_____

Pre Certification Required? Yes/ No (circle one)

Is there a secondary Insurance? Yes/No (circle one)

Patient Medical Information

Today's Date: _____

Patient Name: _____Date of Birth _____

Parent/Guardian's Name(s): _____

Siblings Names and Ages: _____
_____

Reasons for Referral: _____

Is there another language other than English spoken in the home? **Yes/No**
Does the child speak the language**? Yes/No**
Which language does the child prefer? _____

Medical History

Please circle appropriate and complete all questions

Prenatal/Neonatal History:

With this pregnancy were there any complications? **Yes/No**
If Yes, please explain: _____

Was this pregnancy full-term? **Yes/No**
If no, gestational age (how many weeks):
_____

Was labor induced? **Yes/No**
Was Baby delivered vaginally? **Yes/No**
Was the child one of multiple births? **Yes/No**

Was baby in NICU? **Yes/No**
If Yes, please explain: _____

Did baby require NG tube, OG tube or G-tube? **Yes/No**
If Yes, please explain: _____

Any other complications during/after birth? **Yes/No** If yes please explain:_____
_____

Feeding History:
Is there a history of problems with sucking, swallowing or feeding? **Yes/No**
If Yes, please explain: _____
Is there a history of reflux? **Yes/No**
Does your child drink from an open cup? **Yes/No**
Does your child drink from a covered cup? **Yes/No**

Does your child have difficulty chewing? **Yes/No**
Does your child still drool? **Yes/No?**

History of Illnesses:
History of ear infection? **Yes/No**
If Yes, is there a diagnosis of chronic Otitis Media (OM)? **Yes/No**

History of Seizures? **Yes/No**
Has your child had any special tests done (i.e. MRI scan)? **Yes/No**
If Yes, please explain: _____

Has your child had a recent Hearing Test? **Yes/No**
If Yes, what was the date and result: _____

Is there a history of:

	Yes	No		Yes	No
Allergies	___	___	Numbness	___	___
ADD/ADHD	___	___	Stroke	___	___
Sinus Infection	___	___	Paralysis/Paresis	___	___
Asthma	___	___	Incoordination of face or tongue muscles	___	___
Learning Disability	___	___	Genetic Disorder	___	___
Broken Nose	___	___	Influenza	___	___
Bronchitis	___	___	Mouth-Breathing	___	___
Chronic Colds	___	___	Pneumonia	___	___
Chronic Laryngitis	___	___	Physical defect	___	___
Chronic rhinitis	___	___	Cleft Palate	___	___
Poliomyelitis	___	___	Ear Disease	___	___
Rheumatic Fever	___	___	Scarlet Fever	___	___
Hearing problem	___	___	Syphilis	___	___
Typhoid Fever	___	___	Psychological counseling	___	___
Tremor/Twitching	___	___	Glandular imbalance	___	___
Ulcers	___	___	Hyperthyroidism	___	___
Visual Problem	___	___	Hypothyroidism	___	___
Hormone therapy	___	___	Whooping Cough	___	___
Heart Trouble	___	___	Hypertension	___	___
Drug Use	___	___	Drug Use (non-medicinal)	___	___

Other_____

If the answer to any of the above items is "Yes" please explain:
Other relevant illnesses and dates:
_____
_____

Hospitalizations:
Hospital: Date: Reason:
_____
_____

Current Medications:
Name of Medication : Prescribing Reason:

_____

Speech-Language Development:

Do you have concerns about speech/language development? **Yes/No**
If Yes, please explain: _____
_____
_____
_____

Does your child:

	Yes	*No*	*What age?*
Babble/Coo			
Imitate Words			
Produce Words Produce Sentences			
Look in the Direction of Sounds			
Follow Simple Commands			
Communicate with phrases/sentences?			

SENSORY
DOES YOUR CHILD DISLIKE OR OVERLY SENSITIVE TO ANY OF THE FOLLOWING:
_____GLUE _____SAND _____ NAILS TRIMMING _____WATER _____GRASS
_____MEAT _____SPINNING _____ TOOTH BRUSHING _____HAIR CUT _____CLIMBING
_____SWINGING _____LOUD NOISES_____CLOTHING TAGS
DOES YOUR CHILD SEEK OUT:
_____ ROCKING _____ TWIRLING _____ SPINNING _____ROUGH HOUSE
_____ JUMPING _____ TEXTURES _____ MOUTHING TOYS
DOES YOU CHILD APPEAR:
_____INSENSITIVE TO PAIN _____DISTRACTED BY SOUND _____AGGRESSIVE
_____CLUMSY _____EASILY FUSTRATED
_____ TO HAVE DIFFICULTY WITH PUZZLES / MANIPULATIVES
PLEASE ADD ANY ADDITIONAL COMMENTS REGARDING THE ABOVE SENSORY ITEMS THAT WERE CHECKED, IF NEEDED: _____
_____

School Therapy History:

Does your child attend school? **Yes/No**
If Yes, what school? _____
What kind of classroom? _____
Has /does your child receive other therapies? **Yes/No**
If Yes, please explain _____
Are there other concerns you have? **Yes/ No**

If Yes, please explain _____

Therapy Essentials Inc

CONSENT FOR USE AND DISCLOSURE for PAYMENT & HEALTHCARE OPERATION RIGHT TO RESTICT AND/OR REVOKE AUTHORIZATION

Patient Name: _____

Section A: Consent for Treatment, Payment and Health Care Operations

Consent to Treatment: I hereby grant my authorization and consent to Therapy Essentials Inc. for evaluation and treatment of the named patient for medically necessary conditions and/or developmental delays requiring speech language therapy, and certify that no guarantee of assurance has been made as to the results obtained under the care of Therapy Essentials Inc.

Authorization to Release Medical Records: I authorize Therapy Essentials Inc. to release any medical information in connection with these services to health insurance, physicians, or any other third-party involved in the ongoing treatment of this patient.

In other words, please list the healthcare professionals (i.e. pediatricians, schools etc.) that you give our office authorization to send a copy of the paperwork to and/or discuss results of the evaluation on-going progress etc.

This consent is authorized for the following health care provider(s):

Name:_____Address:_____

Name:_____Address:_____

Name:_____Address:_____

I understand that I have the right to review this office's Notice of Information Practices upon request or receive an electronic copy via e-mail. I understand that I have the right to request that this provider restrict how protected health information is used or disclosed to carry out treatment, payment or healthcare operations. I have the right to revoke this consent in writing except to the extent that the provider has taken action prior to the revocation. I understand that this authorization is voluntary.

_____ _____

Signature of patient or patient's representative Date

_____

Printed name of patient's representative:

Assignment of Benefits and Financial Responsibility:

I hereby assign all medical and/or therapy benefits to which I am entitled, including government sponsored programs, private insurance and other health plans to Therapy Essentials Inc. The assignment shall remain in effect until revoked by me in writing. I hereby authorize said Assignee to release all information necessary to secure the payment, which is to be issued to Therapy Essentials Inc. for their service as described herein.

As a courtesy Therapy Essentials Inc. will bill your insurance carrier, however I understand that I am financially responsible for all charges whether or not paid by said insurance. I agree to pay Therapy Essentials Inc. co-payments, deductibles, and coinsurance amounts at the time of service. All other monies due shall be paid upon receipt of invoice from Therapy Essentials Inc.

I understand that I may be charged 18% annual interest on any unpaid balance that is 31 days or more past due. I further agree to pay all collection costs and attorney fees should the account become delinquent and be referred to a collection agency. A $30.00 fee will be charged for all returned checks. Any insurance policies that require precertification is the responsibility of the patient and/or policy holder. Claims denied due to non-receipt of precertification will be billed to the patient or policy holder.

Our office will work with you and your family in every way possible to locate funding sources for therapy.
We will help you determine if your particular plan includes therapy benefits for your child. However, you need to be aware that we CANNOT TAKE ANY RESPONSIBILITY for the DECISIONS made by YOUR INSURANCE COMPANY.

*If there is a balance on your account statements will be mailed every 2 weeks and payment is expected within 7 days of the invoice date. If your account becomes past due, we will take the necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all of the fees which are incurred. If an account is referred to a collection agency, due to non-payment, the providers of Therapy Essentials Inc. will no longer provide therapy services to you and/or your family member.

BCBS Policyholders: I agree to immediately forward to Therapy Essentials Inc. all information and payments sent by BCBS to policyholder. I understand that failing to immediately forward all information and payments from BCBS to Therapy Essentials Inc. could increase my financial responsibility due to claims being processed incorrectly or for any other reason. The Assignment of Benefits and Financial Responsibility Consent above also applies to BCBS policyholders.

Cancellation/No Show Policy: I understand Therapy Essentials Inc. will charge me $30 for missed visits and/or cancellations within 24 hours. I also understand that Therapy Essentials Inc. reserves the right to terminate therapy services provided to the above named patient after two (2) missed within a 4 week period.

Out of the Office Appointments: Appointments scheduled for out of the office will be allotted a 30 minute window for arrival times. We will make a conscious effort to arrive at the designated time however, due to traffic, weather, and other unforeseen circumstances we cannot commit to a specific arrival time.

Payment for Services Rendered:
Our current prices are as follows:

PROCEDURE PRICES

Evaluation $250.00
Extended Evaluation $300.00
Speech/Language Therapy $75/30 minutes or $150.00/hr
Feeding/Oral Motor Therapy $100/30 minutes or $200.00/hr
IEP Family Conference $150.00/hour

_____

Child's Name Parent's Signature Date