NORTH NAPLES
Therapy & Enrichment
SERVICES • P.A.

Identifying Information

Patient Name: ______________________________ Date of Birth: ______________ Age: ______ M F

Current Diagnosis (if any): ____

Home Address: ____

____

Child's Primary Physician: ____

Address/Phone: ____

____

School Attended: ______________________________ Teacher: _________________ Grade: _______

School Phone: ______________________________

Parent/Guardian Information

First Guardian Name: ______________________________ Relationship to Patient: ______________

Primary Occupation: ____

Primary Phone: ______________________________ (circle one) Cell Home Work

Secondary Phone: ___________________________ (circle one) Cell Home Work

Email Address: ____

Second Guardian Name: ______________________________ Relationship to Patient: ______________

Primary Occupation: ____

Primary Phone: ______________________________ (circle one) Cell Home Work

Secondary Phone: ___________________________ (circle one) Cell Home Work

Email Address: ____

Emergency Contact: ______________________________ Relationship to Patient: ______________

Phone: ____

Child Lives With

___ Birth Parents ___ Adoptive Parents ___ Foster Parents

___ One Parent ___ Grand Parent(s) ___ Birth Parents (divorced)

___ Parent and Step-Parent ___ Other (Please explain ____________________________________)

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Patient Name: ______________________________ DOB: ________________________

Siblings/Other Children in the Family

Name	Age	Sex	Grade	Speech/Language/OT Needs

Prenatal & Birth History

Please check all that apply:

___ Full term
___ Low birth weight
___ Breech birth
___ Planned C-section
___ Emergency C-section
___ Premature ______ weeks
___ Vacuum Delivery
___ Vaginal birth
___ Forceps Delivery
___ Preeclampsia
___ Poor suction/latch
___ Oxygen at birth
___NICU stay (duration ____________)
___ Other: ___________________________
____

Was there anything unusual about the pregnancy? No Yes (please explain):

____

How old was the mother when the child was born? _________________________________

Was the mother sick during the pregnancy? No Yes (please explain):

____

Did the child go home with their mother? Yes No (please explain):

____

Developmental Milestones

Please fill in the blanks to the best of your ability.

Sat at ____________________ months/years
Crawled at ________________ months/years
Stood at __________________ months/years
Walked at _________________ months/years
First words ________________ months/years
Spoke in sentences ___________ years
Ran at ____________________ months/years
Dressed at ________________ months/years
Toilet trained at ____________ months/years
Fed self at ________________ months/years
Put two words together ________ months/years

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Patient Name: ________________________________ DOB: ___________________________

Medical History

Please check all that apply and provide dates/explain where space is provided:

___ Chronic ear infections
___ Ear tubes (__________)
___ Compromised immune system
___ Frequent colds
___ Heart condition (_________)
___ Sinusitis (__________)
___ Measles (__________)
___ Mumps (__________)
___ Vision difficulties (__________)
___ Asthma
___ Abnormal muscle tone
___ Torticollis
___ Thumb sucking habit
___ Adenoidectomy (__________)
___ Head injury (__________)
___ Seizures (__________)
___ Meningitis (__________)
___ Other serious injuries (______________________________)
___ Poor weight gain
___ Breathing difficulties
___ High fevers
___ Sleeping difficulties
___ Encephalitis (__________)
___ Chicken pox (__________)
___ Tonsillectomy (__________)
___ Scarlet Fever (__________)

Medical History Continued:

Is you child currently or was recently under physician's care? No Yes (please explain):

____

____

Has your child ever had a significant illness/hospitalizations? No Yes (please explain):

____

____

Does your child have medical precautions? No Yes (please explain):

____

____

Has your child ever had any surgical procedures? No Yes (please explain):

____

____

Does your child have any allergies? No Yes (please explain):

____

____

Is your child on any medication? No Yes (please list any they take regularly):

____

____

Check off all adaptive equipment your child uses:

___ Wheelchair ___ Walker ___ Hearing aids ___ Communication device
___ Eye glasses ___ Crutches ___ Other: ______________________________

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Patient Name: ________________________________ DOB: __________________________

Academic History

Please check all that apply:

___ Does well in school

___ Is not enrolled in school

___ Challenged by school

___ Challenged by reading

___ Challenged by writing

___ Is in a self-contained classroom

___ Is an A B C D F student

___ Does well except for: ______________________
____

___ Receives tutoring for: ______________________
____

___ Repeated a grade: ________________________

Please list any academic concerns:

____
____

Behavioral/Social History

Please check all that apply:

___ Is social and engaging

___ Has difficulty paying attention

___ Poor coping skills

___ Unable to self-calm

___ Has difficulty listening

___ Is very busy and active

___ Prefers to play alone

___ Has tantrums

___ Has difficulty with change

___ Is aggressive

___ Poor eye contact

___ Does not like new places/people

___ Has difficulty with transitions

___ Does not like crowds

___ Quickly escalates with no apparent reason

___ Pays attention

___ Listens well

___ Understands safety

___ Takes turns with peers

___ Follows directions well

___ Plays well with others

___ Is easy going

Additional Comments:

____
____
____

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Patient Name: ______________________________ DOB: ________________________

Speech, Language, Hearing, Occupational History

Is there a language other than English spoken in the home? No Yes (please list):
____

Does the child speak the language? No Yes

Does the child understand the language? No Yes

Who speaks the language? ____

Which language does the child prefer to speak at home? __________________________

Do you feel your child has a speech problem? No Yes (please describe):
____
____

Has your child ever had a speech evaluation? No Yes

If yes, where and when? ____

What were the results? ____

Has your child ever had a hearing evaluation/screening? No Yes

If yes, where and when? ____

What were the results? ____

Has your child ever received any speech therapy? No Yes

If yes, where, when, and for how long? ______________________________

What were you told? ____

Has your child ever had an occupational therapy evaluation/screening previously? No Yes

If yes, where and when? ____

What were the results? ____

Has your child previously received Occupational Therapy? No Yes

If yes, where, when, and for how long? ______________________________

What were you told? ____

Has your child every received a psycho-educational evaluation? No Yes

If yes, where and when? ____

What were you told? ____

Is your child receiving any other services such as Physical Therapy, Counseling, Vision, etc.? No Yes

If yes, please explain: ____

Is you child aware of or frustrated by speech, language, or occupational difficulties? No Yes

If yes, please explain: ____

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Patient Name: ______________________________ DOB: ________________________

What do you see as you child's most significant problem in the home?

____

____

What do you see as you child's most significant problem in the home?

____

____

What are your primary areas of concern/goals for therapy?

____

____

____

How did you hear about us?

____

____

____

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Patient Name: ______________________________ DOB: ________________________

Authorization for Treatment

I, ______________________, acknowledge and agree to have my child, ______________________ participate in therapy services at North Naples Therapy & Enrichment Services, P.A. I acknowledge that there is some inherent risk in the use of the therapy equipment. I hereby release North Naples Therapy & Enrichment Services, P.A., its principal owners, therapists, employees, representatives, and all other individuals or organizations acting on behalf North Naples Therapy & Enrichment Services, P.A. in connection with this program from any and all claims which I or my child may have arising from, resulting from, or in connection with my child's participation in therapy including, but without limitation, any claim, demands, or causes of action for injuries to my child, including but not limited to, injuries resulting from the use of any play equipment during the program. This agreement is signed for the purpose of fully and completely releasing, discharging, and indemnifying North Naples Therapy & Enrichment Services, P.A., its principal owners, therapists, employees, representatives, and all other individuals or organizations acting on behalf of North Naples Therapy & Enrichment Services, P.A., in connection with this program from all liability as herein described.

_________________________________ ______________________

Signature of Parent/Guardian Date

Video/Photography Release

_____ **I DO** hereby authorize North Naples Therapy & Enrichment Services, P.A. to capture my child's therapy sessions via photography or videography for therapeutic purposes only to document therapeutic interventions executed during my child's session. I authorize these forms of media to be shared between the treating therapist and parents/caregivers and/or another therapist within North Naples Therapy & Enrichment Services, P.A. for consultative purposes via text message, email, or shared in person. All such documentation is considered highly confidential and will not be utilized for public viewing or media purposes.

____ **I DO NOT** authorize North Naples Therapy & Enrichment Services, P.A. to record my child via photography or videography during his/her session.

_________________________________ ______________________

Signature of Parent/Guardian Date

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Patient Name: ______________________________ DOB: ________________________

Release for Education and Teaching Purposes

I hereby authorize the therapists at North Naples Therapy & Enrichment Services, P.A. to allow my child to occasionally be observed during therapy sessions by fieldwork students/interns and/or volunteers in our usual practice. I understand that these individuals will be signing confidentiality agreements as mandated by HIPAA and that any information will be used for teaching purposes only.

_________________________________ _____________________

Signature of Parent/Guardian Date

Patient Name: ______________________________ DOB: ________________________

Authorization for Release of Identifying Health Information

I hereby authorize North Naples Therapy & Enrichment Services, P.A. to release or obtain medical, academic, and other pertinent information to and from my child's physicians, teachers, and/or other related specialists. This information may be released to and from North Naples Therapy & Enrichment Services, P.A. through verbal and/or written correspondence. I understand that this information will be kept confidential and only be utilized for medical or educational purposes.

May we send you text messages as a form of communication? Yes No

May we use email to send therapy related information? Yes No

This release of information will remain in effect until terminated by patient/guardian in writing. The only exception to revocation is if we have already acted in reliance upon the authorization.

_________________________________ _____________________

Printed name of Parent/Guardian Relationship to patient

_________________________________ _____________________

Signature of Parent/Guardian Date

Patient Name: ____________________________________ DOB: _____________________________

Notice of Privacy Practices – Acknowledgement and Consent

Under the Health Insurance Portability and Accountability Act of 1996, or HIPAA, I understand that I have certain rights to privacy regarding my child's therapy information.

I understand North Naples Therapy & Enrichment Services, P.A. will use my child's therapy records in the following ways:

- North Naples Therapy & Enrichment Services, P.A. will use your child's records to treat your child and to bill for the services that we provide.
- North Naples Therapy & Enrichment Services, P.A. will use your child's records to plan and direct treatment and follow-up among various providers including, but not limited to therapists, physicians, and educators who may be involved both directly and indirectly with your child and their well-being.
- North Naples Therapy & Enrichment Services, P.A. will share your child's records if required to, for any reason by law.

You have the following rights with regard to your child's records:

- You have the right to look at and receive a copy of your child's records,
- You have the right to receive a list of whom we have given your child's records to.
- You have the right to ask us to correct a mistake in your child's records.
- You have the right to ask that we not use or share your child's records.
- You have the right to ask us to change the way that we contact you.

Please print patient's complete legal name: ____

Patient's date of birth: ____

Printed name of parent/legal guardian: ____

Signature of parent/legal guardian: ____

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Patient Name: ______________________________ DOB: ________________________

Fees for Services

Speech-Language Services	
Comprehensive Speech and Language Evaluation (Preschool aged)	$400.00
Comprehensive Speech and Language Evaluation (School aged)	$450.00
When added to a comprehensive speech and language evaluation:	
Auditory/Phonological Processing	$150.00
Written Language	$150.00
Higher Level Language	$150.00
Fluency	$150.00
Executive Functioning	$150.00
Articulation Testing	$175.00
Speech and Language Therapy Sessions	$125.00/hour

Occupational Therapy Services	
Comprehensive Occupational Therapy Evaluation	$425.00
Fine Motor Evaluation (Handwriting)	$350.00
Occupational Therapy Sessions	$120.00/hour
Comprehensive Multidisciplinary Evaluation (Speech, Language, OT)	$775.00

Hour long sessions will consist of 50 minutes of one-on-one therapy, with 10 minutes allotted to speak with the parent or teacher and documentation time. *45 minute minimum for individual therapy sessions

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Patient Name: ______________________________ DOB: ________________________

Billing Policy

All billing is done by credit card, every two weeks. Please complete the following information and return with your intake paperwork.

Name on Card ____

Card Number ____

Expiration Date ____

Security Code ____

Billing Address for Card ____

Email Address for Invoice ____

We accept Visa, Mastercard, Discover, and American Express.

North Naples Therapy & Enrichment Services, P.A. does not accept insurance for payment or submit claims to your insurance. You will be provided with a bi-weekly statement which will include the necessary treatment codes and information for you to submit to your insurance company if you have coverage for Speech and Language or Occupational Therapy services.

I have read and understand the Billing Policy and agree to abide by the policy as defined above.

_________________________________ _____________________

Signature of Parent/Guardian Date

Patient Name: ______________________________ DOB: ________________________

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Patient Name: ___________________________________ DOB: ____________________________

Cancellation/Late Policy

All non-emergency cancellations require at least 24-hour notice. Non-emergencies include vacations, preplanned medical appointments, family events, parties, lack of a babysitter, sports events, or anything not designated as an "emergency" (see description below). If nonemergency cancellations become excessive, the client may lose their weekly slot in the clinician's schedule.

If you do not cancel a session prior to the therapist's arrival at the school, your home, or you fail to show for the appointment, you will be billed half of the session rate.

Emergencies require notification of at least one hour, prior to the treatment session. Emergency cancellations are accepted for illness, or illness of a family member. Please do not come, or bring your child, to the office with a fever, strep throat, an unidentified rash, diarrhea, vomiting, or any other highly contagious illness. You or your child must be fever-free for at least 24 hours prior to the session. If you or your child arrives ill, you will be dismissed and charged for the session.

Please understand we have a waiting list for therapy services. We take careful attendance. If cancellations exceed 25%, we may have to dismiss your child from therapy to make room for children on our wait list.

Make-Up Policy – We offer make-up sessions, as they are in your child's best interest. These sessions are offered for illness and pre-arranged vacations/holidays. Make-up sessions will not be offered when there is a violation of the cancellation policy. For example, if you are charged for a no-show, we will not reschedule that visit. Make-ups must be attempted for vacations and cancellations. Failure to schedule make-ups is considered a violation of the Cancellation Policy.

Arrival Time – It is crucial to be on time for your child's session. There is typically another session scheduled after your child, so it is unlikely that the therapist will be able to extend your session if you are late. You will be billed for the entire session when you are late.

I have read and understand the Cancellation Policy and agree to abide by the policy as defined above.

_______________________________________ ___________________________

Signature of Parent/Guardian Date