Children's Therapy Solutions, Inc.
Intake Packet

IDENTIFYING INFORMATION

Child's Name: _____ Sex: Male _____ Female _____

Date of Birth: _____ Hospital/City, State: _____ Age: _____

Mother's Name: _____ Date of Birth: _____

Biological Parent: _____ Relative: _____ Foster Parent: _____
Step Parent: _____ Adoptive Parent: _____

Father's Name: _____ Date of Birth: _____

Biological Parent: _____ Relative: _____ Foster Parent: _____
Step Parent: _____ Adoptive Parent: _____

Address: _____
Street City State Zip Code

Home Phone #: _____

Mother Cell Phone #: _____ Father Cell Phone #: _____

Mother Work Phone #: _____ Father Work Phone #: _____

Email(s): _____

Emergency Contact/Relation: _____ Emergency Phone #: _____

Primary Care Physician Name and Address: _____

_____

Insurance Provider: _____
(Please provide Insurance Card to front office staff)

Social Security Number: _____

Please Explain Reason For Visit Today:

_____

_____

_____

MEDICAL HISTORY

Has the child ever been hospitalized for illness, physical ailments, emotional problems, etc? YES _____ NO _____
If yes, please explain where, when and what for. _____

_____
_____

Has the child ever taken, or is he/she currently taking any medications? YES _____ NO _____
If yes, please list medication name, frequency and dosage. _____
_____

Does the child have any allergies that you are aware of (i.e. latex, peanuts, soy, etc.)? _____
_____

LIVING ARRANGEMENTS

Number of moves in child's life: _____ Ever placed, boarded or lived away from family? YES _____ NO _____
Please explain: _____

Current home: Rent _____ Own _____
House _____ Apartment _____

List all members of your household presently and indicate their relation to the child: _____
_____
_____
_____

Are you interested in counseling services for yourself or any of your family members? YES _____ NO _____

DEVELOPMENTAL HISTORY

Did mother have any illness or complication during pregnancy? YES _____ NO _____
If yes, please explain. _____
_____
_____
_____

Did mother abuse alcohol or drugs during pregnancy? YES _____ NO _____

Length of pregnancy _____ Birth weight: _____ lbs _____ oz

Were there any complications at birth? YES _____ NO _____
If yes, please explain. _____
_____
_____
_____

EDUCATIONAL HISTORY

Name of School/Daycare: _____

Type of class: Regular Education _____ Inclusion _____ ESE Functional Life Skills _____
VE _____ EBD _____ Other (explain) _____

Does the child receive special services at school? YES _____ NO _____
If yes, which services does he/she receive and what is the frequency of each?

_____ Language Therapy _____ minutes per week
_____ Speech Therapy _____ minutes per week
_____ Occupational Therapy _____ minutes per week
_____ Physical Therapy _____ minutes per week
_____ Counseling _____ minutes per week

SOCIAL HISTORY

Does the child participate in extracurricular activities? YES _____ NO _____
If yes, what activities and how often? _____
_____

In school, how many friends does the child have? _____
_____

_____
Name of person providing information Relationship to child Date

EYBERG CHILD BEHAVIOR INVENTORY

Directions:
Below is a series of phrases that describe a child's behavior. Please
(1) circle the number describing how often the behavior occurs with your child and
(2) circle either "yes" or "no" to indicate whether the behavior is currently a problem.

(1) – Never (2) – Almost never (3) – Seldom (4) – Sometimes (5) – Often (6) – Almost Always (7) – Always

1	Dawdles in getting dressed	1 2 3 4 5 6 7	YES	NO
2	Dawdles or lingers at mealtimes	1 2 3 4 5 6 7	YES	NO
3	Has poor table manners	1 2 3 4 5 6 7	YES	NO
4	Refuses to eat food presented	1 2 3 4 5 6 7	YES	NO
5	Refuses to do chores when asked	1 2 3 4 5 6 7	YES	NO
6	Slow in getting ready for bed	1 2 3 4 5 6 7	YES	NO
7	Refuses to go to bed on time	1 2 3 4 5 6 7	YES	NO
8	Does not obey house rules on his/her own	1 2 3 4 5 6 7	YES	NO
9	Refuses to obey until threatened with punishment	1 2 3 4 5 6 7	YES	NO
10	Acts defiant when told to do something	1 2 3 4 5 6 7	YES	NO
11	Argues with parents about rules	1 2 3 4 5 6 7	YES	NO
12	Gets angry when doesn't get own way	1 2 3 4 5 6 7	YES	NO
13	Has temper tantrums	1 2 3 4 5 6 7	YES	NO
14	Sasses adults	1 2 3 4 5 6 7	YES	NO
15	Whines	1 2 3 4 5 6 7	YES	NO
16	Cries easily	1 2 3 4 5 6 7	YES	NO
17	Yells or screams	1 2 3 4 5 6 7	YES	NO
18	Hits parents	1 2 3 4 5 6 7	YES	NO
19	Destroys toys and other objects	1 2 3 4 5 6 7	YES	NO
20	Is careless with toys and other objects	1 2 3 4 5 6 7	YES	NO
21	Steals	1 2 3 4 5 6 7	YES	NO
22	Lies	1 2 3 4 5 6 7	YES	NO
23	Teases or provokes other children	1 2 3 4 5 6 7	YES	NO
24	Verbally fights with friends his own age	1 2 3 4 5 6 7	YES	NO
25	Verbally fights with brothers and sisters	1 2 3 4 5 6 7	YES	NO
26	Physically fights with friends	1 2 3 4 5 6 7	YES	NO
27	Physically fights with brothers and sisters	1 2 3 4 5 6 7	YES	NO
28	Constantly seeks attention	1 2 3 4 5 6 7	YES	NO
29	Interrupts	1 2 3 4 5 6 7	YES	NO
30	Is easily distracted	1 2 3 4 5 6 7	YES	NO
31	Has short attention span	1 2 3 4 5 6 7	YES	NO
32	Fails to finish tasks or projects	1 2 3 4 5 6 7	YES	NO
33	Has difficulty entertaining himself alone	1 2 3 4 5 6 7	YES	NO
34	Has difficulty concentrating on one thing	1 2 3 4 5 6 7	YES	NO
35	Is overactive or restless	1 2 3 4 5 6 7	YES	NO
36	Wets the bed	1 2 3 4 5 6 7	YES	NO

Children's Therapy Solutions, Inc.
RELEASE OF INFORMATION

You may consent for personal information contained within your clinical record held by Children's Therapy Solutions, Inc. to be disclosed to the persons and/or agencies identified below for the following reasons:

- Planning and monitoring appropriate treatment
- Case review and consultation with your physician and/or health care providers
- Support and/or involvement of family member(s) or significant others in treatment
- Information that is required to file a claim with your insurance company or managed care company
- Information required by your employer if you are referred to treatment by your supervisor

Your signature indicates that you authorize Children's Therapy Solutions, Inc. to release/receive information to the parties named below. You may revoke this consent at any time by providing written notice. Please refer to the HIPAA guidelines for additional privacy information.

1. Name of the person *who referred you/your child* for services: _____
   Address: _____
   Phone #: _____

2. Name of *primary care physician* (if different from above): _____
   Address: _____
   Phone #: _____

3. Any other parties (*i.e. attorney, employer, community agency, school)* that you authorize Children's Therapy Solutions, Inc. to give/receive information regarding your/your child's treatment: _____
_____
_____
_____

4. *Family member(s)/significant other* who may participate in therapy. Please indicate relationship to child.
_____
_____

Child's Name: _____ Date of Birth: _____

Parent/Guardian Signature: _____ Date: _____

Witness by: _____ Date: _____

Children's Therapy Solutions, Inc.
HIPPA NOTICE OF PRIVACY PRACTICES

Our commitment here at Children's Therapy Solutions, Inc. is to serve our clients with professionalism and caring. We want to protect the privacy and security of all Protected Health Information.

During the course of serving your interests, it may be necessary to share information with other health care providers or business associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a specialized study (such as a swallow study)
- For payment purposes, we may use the services of a billing service and or billing clearing house software.
- During health care operations, we may need a specialized evaluation and/or consult services

We are Children's Therapy Solutions, Inc. are committed to obeying all federal, state and local laws and regulations regarding Privacy Practices. If any other uses or disclosures other than the ones listed above are needed, information will only be released with your written authorization (parent or legal guardian of a minor). This written authorization may be revoked at any time by the individual (parent or legal guardian of a minor) as provided by law.

If you have any questions or comments regarding your Protected Health information, feel free to contact our Compliance Officer, Lena Thoresen at (941) 745-5111.

I have read and understand the above HIPPA Notice of Privacy Practices.

Client Name: _____

Signed: _____ Date: _____
(client, parent or legal guardian)

FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

I was presented and reviewed the Florida Patient's Bill of Right and Responsibilities. I am aware that I can request a copy at any time.

Client Name: _____

Signed: _____ Date: _____
(client, parent or legal guardian)

Children's Therapy Solutions, Inc.
INFORMED CONSENT

PROCESS OF THERAPY:
The purpose of therapy is to facilitate change in order to achieve one's goals. If you agree to participate in therapy, it will consist of the following parts, and more details about each part are given below:

- A screening – an Evaluation or Assessment
- Development of mutually agreed upon treatment plan and goals
- Individualized treatment
- Follow through with clinic treatment and/or home program, as needed
- Family or Caregiver teaching and/or participation, as needed

** You have the right to withdraw from therapy at any time without consequences and we can provide you with information about other services. _____ **INITIAL**

DISCLOSURE OF INFORMATION:
It is important for you to know that you do not have to answer any question in either the interview or questionnaires. Questions are used to obtain information for evaluation and planning purposes and are never intended to make you feel uncomfortable. If you do, please talk to your therapist about your feelings in this regard. _____ **INITIAL**

HEALTH INSURANCE & CONFIDENTIAL RECORDS:
Disclosure of confidential information may be required by your health insurance carrier or other third part payer in order to process claims. Only the minimum necessary information will be provided. I am aware that if my insurance company denies claims or fails to pay, I am responsible for my balance. _____ **INITIAL**

CONFIDENTIALITY:
Your identity will be kept confidential to the extent provided by law. All information that you give us during therapy, including anything that you tell us during assessment interviews or during treatment and any information that you provide on questionnaires and other test, is confidential. This means that we will not tell or give anyone any information about you without your written permission, unless you give us information that suggests to us that you or anyone in your family may be a danger to yourself or others, including information that suggests child abuse.
_____ **INITIAL**

WHEN DISCLOSURE IS REQUIRED BY LAW:
Professionals who work with families must report information of abuse or danger to self and/or others to authorities to protect you and your family. Since CTS has a "Zero Tolerance" policy regarding any form of abuse, we have posted the Abuse, Neglect/Exploitation phone numbers on the bulletin boards in the waiting area of the CTS office.
_____ **INITIAL**

Agreement:

I have read the procedure described above. I voluntarily agree to participate in therapy and I have received a copy of this description.

Client Name: _____

Relationship to Client: _____

Parent/Guardian Signature: _____ **Date:** _____

Children's Therapy Solutions, Inc.
PICTURE/VIDEO RELEASE

I, _____, (Print Parent/Guardian's Name) will allow Children's Therapy Solutions, Inc. to take pictures and/or video recordings of my child, _____ (Print client's name) during therapy sessions. I understand that by giving consent, I am also giving permission for Children's Therapy Solutions, Inc. to utilize these pictures/video recordings in any of the following ways including, but not limited to: website, Facebook, educational resources, news materials/articles, and in promotional materials for Children's Therapy Solutions, Inc. and Manatee Hope, Inc. I also understand that my child's picture/video recording will never by use in conjunction with my child's last name.

Parent/Guardian Signature: _____ Date: _____

Children's Therapy Solutions, Inc.
CANCELLATION POLICY

Physical, Speech/Language, Mental Health and Occupational Therapy Scheduling, Cancellation and Payment Policies

Since 2004, Children's Therapy Solutions, Inc. has proudly served children and families of Manatee County and the surrounding areas. Our therapists are dedicated to providing the best possible programs and services to help individuals achieve maximum improvements.

Our staff of highly trained therapists is working hard to help you and/or your child and your family. We care deeply and passionately about providing quality service to the children and families with which we work. We understand that people get sick and it's not always possible to give notice. However, the earlier you can inform us of the cancellation, the sooner we can fill that appointment with another client's make-up session of someone needing a specific time period for therapy.

SCHEDULING POLICY:
Initial appointments are usually scheduled within 2-4 weeks of initial contact. If you are unable to attend one of the appointments that you have scheduled, we require at least 24 hours notice to avoid a possible cancellation fee. Please check in with our receptionist and sign in at the front desk. All copays are due before each session.

_____ **INITIAL**

CANCELLATION POLICY:
Any cancellation of an appointment made within 24 hours of the appointment may be subject to a $35 cancellation fee. Monday appointments should be canceled prior to 7:00 a.m. on Monday to avoid this fee. Cancellations may be left on the Children's Therapy Solutions, Inc. voicemail prior to 7:00 a.m., or texted, if necessary. The only exception to this policy will be a true emergency such as hospitalization or a death in the family. Please note, our location is conveniently located next to public bus transportation if you need to access public transportation. If you must cancel, please call our office at (941) 745-5111. In the event no one is available, be sure to leave a message. The voicemail will be checked several times a day.

We ask that you reschedule your appointment within the same week. Cancelling for any reason (except due to a death in the family or hospitalization) without making up the session within the same week may result in losing your preferred appointment time.

In you cancel more than one time in a 30-day period, your preferred appointment time will no longer be guaranteed. This applies to cancellations for any reason. More than one canceled appointment within a 30-day period, not within a calendar month, may result in losing your preferred appointment time. **Please remember that when you cancel, you are not adhering to the treatment plan set by your therapist.**

If your child is sick, you may also bring us a doctor's note and we will waive any possible cancellation fee that may be changed. _____ **INITIAL**

WEATHER CONDITIONS:
CTS does NOT follow the inclement weather schedule of the surrounding school districts. If we close our office early or your therapist cancels due to weather conditions, you will be contacted by our office. If a decision is made to close the office for the entire day due to inclement weather, you will be contacted by our office.

Otherwise, our office will be open. We would never want anyone to travel when they are not comfortable with the weather and road conditions. Cancellation consequences may be waived by CTS due to inclement weather, but you must call our office to cancel prior to the appointment time. A no show free of $50 may be charged for appointments missed with no notification. _____ **INITIAL**

INSURANCE AUTHORIZATION:
If an appointment must be cancelled because of lack of insurance authorization, no fees will be charged. If insurance authorization cannot be obtained in a timely manner, we reserve the right to fill your time slot with another client.

_____ **INITIAL**

COPAYS and COINSURANCE PAYMENTS:
Any copays and coinsurance balances must be paid at the time of each appointment. You must pay your copay of the rate you are responsible for at the check-in window BEFORE the session.

We accept all forms of payment including all major credit cards. We do offer a payment plan option where you will receive a discount if you pay for future visits. Please contact our front office if you are interested in learning more about these options. We reserve the right to discontinue treatment if no attempt to resolve past due balances is made.

_____ **INITIAL**

Client's Name: _____

Signature – parent or responsible party: _____ Date: _____

Facility Representative: _____ Date: _____

Children's Therapy Solutions, Inc.

Dear Families Served by Children's Therapy Solutions,

First, we would like to take the opportunity to express how glad we are to provide services to your child/family. We are here to assist you in any way we can. If you need additional services or have questions or ideas to improve your care, please feel free to contact us.

In providing the best care possible, it is crucial to attend each scheduled session.