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 you, please also note we will need a copy of your insurance card and a prescription for OT, ST, or PT 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 the office.

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

Kindest Regards,

Jennifer Bluske Krull
Occupational Therapist and Owner
Jen.krull@ctn-madison.com

CLIENT REGISTRATION

Today's Date:_____

Client's Name:_____ Date of Birth_____ Sex: Male_____ Female____

Address: _____City:_____State:_____ Zip Code:_____

Home Phone: _____

(If applicable):

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, please contact the following person(s):

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

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

_____ Date:_____

FOR OFFICE USE ONLY

New Client Folder in "Client Reports"

Entered into Practice Perfect

Insurance Company Called/Coverage Verified

Insurance Card Copy

Script from Referring Physician

Assigned to: _____

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 _____**	**SECONDARY INSURANCE** **Insurance Company _____**
Policy #	Policy #
Group #	Group #
Policy Holder:	Policy Holder:
Policy Holder DOB:	Policy Holder DOB:
Policy Holder Employer:	Policy Holder Employer:
Relationship to client:	Relationship to client:
Telephone # (insurance company)	Telephone # (insurance company)

PHYSICIAN INFORMATION

Referring Physician:	
Hospital or Clinic:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip Code:	

GENERAL HISTORY

EARLY DEVELOPMENTAL HISTORY

Please describe your birth history, (examples: describe any complications during pregnancy, birth or infancy).
Please describe any concerns you have regarding your early development.
Please describe your living situation. Including who lives in the home with you and other important people in your day.

MEDICAL HISTORY

Please check if history of the following:

- ☐ Developmental Delay
- ☐ Hospitalizations
- ☐ Surgery
- ☐ Ear infections
- ☐ Respiratory Problems
- ☐ Gut Issues
- ☐ Food Sensitivities
- ☐ Special Diets
- ☐ Allergies
- ☐ Bowel/Bladder concerns
- ☐ Sleep Issues

If yes to any, please describe:

_____

_____

_____

MEDICATION INFORMATION

Medication Name(s)					
Medication Purpose(s)					
Dosage(s)					
Prescribing Doctor					
Comments					

Has your hearing and vision been assessed? What were the outcomes?
Do you 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 is receiving**. It is very helpful to have pertinent reports available for review prior to the evaluation.** Please list service provider, approximate dates service was provided and duration of treatment.

Professional Type	**Name(s)**	**Contact Information**	**Permission to Release Information?**
Pediatrician or Primary Physician & Clinic			Yes ____ No _____
Specialty Physician & Clinic (psychologist, neurologist, etc.)			Yes ____ No _____
Specialty Physician & Clinic (psychologist, neurologist, etc.)			Yes ____ No _____
Mental Health / Behavioral Therapist & Clinic			Yes ____ No _____
OT/PT/SLP Therapist & 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 _____

School District: _____ Grade: _____

Do you have an IEP: Yes ☐ No ☐ **If yes, please attach a copy to the paperwork.**

SOCIAL DEVELOPMENT

Time spent with peers or friends:
Extracurricular Activities or Hobbies:
What are your typical responses to frustration and conflict?
Do you have any extreme dislikes and/or fears we should know about?
Describe what motivates you:

DAILY ROUTINES

Please describe your eating habits. Please include dietary restrictions/preferences:
Are transitions or changes in routine difficult? Please describe strategies that you have found helpful.
Are there times of the day or activities that are more difficult? What are the triggers?

Please describe your typical daily routines.

Wake-up routine: _____

Afternoon routine: _____

Evening routine: _____

During the night: _____

CLIENT (and/or CAREGIVER) FEEDBACK

What are your main areas of concern?

_____
_____

What are strengths for you and those in your family?

_____
_____
_____

What would be your priorities/goals that you would like to accomplish as a result of therapy services?

_____
_____
_____

Is there anything that would be helpful to know 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 $50.00 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 $105.00, 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

1. 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***

2. 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

1. 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 OF PARENT OR GUARDIAN 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

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

2. 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.**

Date _____Signature _____

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 Ct. Suite 101 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/GUARIDAN (On behalf of patient)

Client Name: _____
Signature: _____
Date: _____

Children's Therapy Network LLC

Release of Protected Health Information

I authorize the use or disclosure of protected health information about:

Client's Name: _____ DOB: _____

I authorize the use or disclosure of protected health information to be released **FROM/TO:**

Individual/Agency: _____
Address: _____
Phone Number: _____ Fax Number: _____

I authorize the use or disclosure of protected Health Information to be released **TO/FROM:**
Individual/Agency: **Children's Therapy Network, LLC**
Address: **14 Ellis Potter Ct, Suite 200, Madison WI 53711**

I authorize the specific information checked below to be used or disclosed:

___ Medication History
___ Psychiatric Evaluation
___ Psychological Evaluation
___ Past/Present Diagnosis
___ Medical Information/history
___ Other_____
___ Intake Assessment
___ Discharge Summary
___ Progress Reports
___ Treatment history
___ Social History
___ Behavioral Information
___ School grades/attendance
___ Recommendation
___ Legal Information

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoke or specified, this authorization will expire in **one calendar year.** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provider in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Person Legally Authorized to Consent for above Individual Date

_____ _____
Witness Date