HELPING HANDS
PEDIATRIC THERAPY SERVICES

Date: _____

Last Name:	**First Name & Initial:**	**Date of Birth:**	**Male Female**
Address:			
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Social Security Number:			

Parent's First and Last Name:	Parent's Social Security Number:
Address:	Date of Birth:
City/State/Zip:	

Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Employer	Employer Phone	Employer Address

Parent's First and Last Name:	Parent's Social Security Number:
Address:	Date of Birth:
City/State/Zip:	

Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Employer	Employer Phone	Employer Address

Primary Insurance Company NAME and PHONE NUMBER:

Primary Policy Number:	Primary Group Number:	Primary Subscriber Name:

Secondary Insurance Company NAME and PHONE NUMBER:

Secondary Policy Number:	Secondary Group Number:	Secondary Subscriber Name:

Emergency Contact Name and Relation to Patient:	Phone Number:

AUTHORIZATION TO PAY BENEFITS TO HELPING HANDS, INC.: I hereby authorize payment directly to Helping Hands, Inc., otherwise payable to me for services rendered, realizing I am responsible to pay non-covered services. I also realize that I am responsible for any other cost incurred while collecting my outstanding balance(s).

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Helping Hands, Inc. to release any information acquired in the course of my treatment necessary to process insurance claims.

_____ _____ _____

Signature (Legal Guardian/Parent, if minor) Date

Helping Hands, Inc. · 2049 Jefferson Davis Highway · Stafford, VA · 22554 · Phone: 540-657-1423 · Fax: 540-657-1424

HELPING HANDS, INC.
RELEASE OF INFORMATION

Patient Name: _____ DOB: _____

I hereby authorize Helping Hands, Inc. to release patient therapy report and other pertinent information to:

Name: _____

Address: _____

_____

Phone: _____

Name: _____

Address: _____

_____

Phone: _____

Name: _____

Address: _____

_____

Phone: _____

List any additional names on separate paper.

This authorization is subject to my written cancellation at any time:

_____ _____

Signature of Parent/Guardian Date

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HELPING HANDS, INC.
FINANCIAL POLICY

PLEASE READ CAREFULLY BEFORE SIGNING

1. NO patient will be seen without a current physician's order. (No exceptions.)
2. **Cancellation and Attendance Policy**: Please refer to separate document.
3. **Your child's therapy is a serious commitment between you and his/her therapist.** Helping Hands, Inc. requires consistent attendance to maximize your child's progress. We reserve the right to terminate therapy in the event that appointments are not attended as scheduled, or if your bill is not paid in a timely manner.
4. **If Helping Hands, Inc. DOES NOT have a contract with your insurance company**, payment is due at the time services are rendered. All documentation needed for you to file a claim with your insurance company will be provided to you upon request.
5. **If Helping Hands, Inc. DOES have a contract with your insurance company**, we will submit your claim to your insurance company. It has become impossible, however, for our staff to be familiar with the separate requirements, and keep up with changes, of each individual or group health care plan. If you are, or you become a member of any health care plan, *it is your responsibility to know what your health care plan will cover and to abide by its rules regarding services in our office as well as referrals, preauthorization's, etc. If you have questions about what your health care plan will and will not cover, you need to contact your plan directly. You are responsible for making your co-payment/deductible at every visit.* Please note that it takes **at least one week** to generate a referral or preauthorization. You are responsible for notifying us of any changes regarding your insurance coverage. We are not responsible for obtaining preauthorization for therapy services if we are not informed of current insurance coverage, and you are responsible for any non-covered and/or denied charges incurred on your child's behalf.
6. If you are a Tricare Prime member, you are responsible for ensuring that all required referrals are submitted to Tricare by your primary care manager (PCM) and corresponding authorization is received by our office. No services will be rendered without prior authorization. The services listed on the authorization will be the ONLY services rendered. You may not request additional services be rendered as they will not be covered by Tricare.
7. You will be billed a $25.00* fee for each check returned by the bank.
8. In the event that an account 60 days or more delinquent is taken to court, you are responsible for all collection and/or attorney fees incurred by Helping Hands, Inc.
9. All co-payments/deductible payments must be made prior to any services being rendered.

**Our office offers automatic payment plan service for co-payments and deductibles. If you are interested in this service, please contact our office for enrollment information.

I authorize HELPING HANDS, INC. to apply for benefits on my behalf for covered services rendered. I request payment to be made directly to HELPING HANDS, INC. I certify that the information I have provided with regard to my insurance coverage is correct, and further authorize the release of any necessary information, including medical information for any related claim, to Helping Hands, Inc.* billing agent and/or my insurance carrier. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing at any time by either me or my insurance carrier.

I have read the above policy and agree to abide by it.

_____ _____

Parent's Name – please print Date

_____

Parent's Signature

**Fees subject to change*

Client Name: _____ Date of Birth: _____

HELPING HANDS, INC.
ATTENDANCE/CANCELLATION POLICY

- **All cancellations must be made 24 hours prior to your appointment.**

- **Appointments that are not cancelled with a 24-hour notice are subject to a $50.00 cancellation fee. If parents/guardians reschedule their child's appointment, we waive this $50.00 fee.**

- **Appointments that are not attended by the patient with no notification to the front office ("No call, no show" appointments) are subject to a $50.00 fee. We do not waive this fee.**

Please Note: When you are cancelling your child's appointment, you must provide notification to the front office. Our therapists are not responsible for communicating their clients' cancellations, scheduling conflicts, and vacation info to the front office. Parents can notify the front office at check-in, check-out, via phone (540-657-1423), via email (office@hhitherapy.com), or through the Contact Us inquiry form on our website (www.hhitherapy.com). Failure to notify the front office can result in your child's appointment being labeled as a "No Call, No Show," and we do not waive that $50 fee; so please be sure to notify the front office when your child will not be able to attend their therapy session(s).

- **All cancellation and no-show fees will be billed directly to you. These fees must be paid before or at the time of your child's next appointment or the child will not be seen.** Neither your insurance company nor your flexible spending account will cover these fees.

- **Our office reserves the right to remove from the schedule a client who is not regularly attending therapy or a client who continuously arrives late.**
    - **Two cancellations of your child's regularly scheduled appointment will result in your child being removed from the schedule effective immediately. The child will then be place on a waiting list if requested.** (If there are extenuating circumstances preventing you from bringing your child to their appointment, please contact the front office to discuss immediately to avoid removal from the schedule.)
    - **Two "No call, no show" appointments 2 weeks in a row will result in your child being removed from the schedule effective immediately.** *(Please note, you must notify the front office if your child will not be here. Therapists are not responsible for communicating that information to the front office staff.)*

- **Our office will make every effort to provide therapy to your child in circumstances where clients are late checking in. If you arrive late to your child's appointment, the session will conclude at its regularly scheduled end time; however, if you arrive more than 30 minutes late, your child will not be seen and you will be required to reschedule the appointment or pay the cancellation fee of $50.00.**

- **We require that an adult be ON SITE during the full length of their child's therapy session. If you are not able to remain on the premises, we require you to reschedule the appointment.**

By signing below, I acknowledge receipt of this attendance & cancellation policy and agree to the terms stipulated above.

_____ _____

Parent's Signature Date

Client Name: _____ Date of Birth: _____

HELPING HANDS, INC.
WEATHER POLICY

We DO NOT operate in coordination with public/private school systems, local government office closings, or federal government closings. **If our office is open, regardless of the weather conditions, parents/guardians are still subject to cancellation/no-show fees.**

During times of inclement weather, any closings and/or delayed opening information will be posted on our website (www.hhitherapy.com). A message will also be available by calling our office (540-657-1423). Should our office close early due to inclement weather, parents will be called immediately to be notified.

SICK POLICY

Your child must be cleared of all sickness and fever for a 24-hour period prior to receiving therapy.

Our office has 24-hour voicemail. You may call at any time during the day or night to notify Helping Hands, Inc. that you need to cancel your child's session. This is a Helping Hands, Inc. policy. All questions regarding this policy should be directed to our practice director/owner, Lisa Worcester, at 540-657-1423.

By signing below, I acknowledge receipt of this attendance & cancellation policy and agree to the terms stipulated above.

_____ _____

Parent's Signature Date

HELPING HANDS, INC.
NOTIFICATION OF FEES

Our office offers the following private pay rates for therapy should Helping Hands not contract with your insurance company:

Occupational Therapy Evaluation: $425.00
Occupational Therapy, 50 minutes: $125.00
Speech Therapy Evaluation: $325.00
Speech Therapy, 30 minutes: $62.50

The following services are not billable to ANY insurance and you will be required to pay for the following if requested (All requests MUST be made at the front desk; any request(s) made directly to the therapist will NOT be honored):

Copies of medical record: $5.00 per copy
Completion of forms: $5.00 per form
School recommendations: $40.00 per request
Meeting attendance: $100.00 per meeting
Observation at outside location: $100.00 per observation

I, _____, have read and understand the Helping Hands, Inc. Financial Policy. I understand that due to the specialization of the services provided by Helping Hands, Inc., I will be responsible for services not covered by my insurance carrier including, but not limited to, co-pays, deductibles, and non-covered services.

_____ _____
Parent's Name – please print Date

**Fees subject to change*

HELPING HANDS, INC.
MEDICAID MCO POLICY

A managed care organization (MCO) is a health care provider or a group or organization of medical service providers who offers managed care health plans. These MCOs agree to provide most Medicaid benefits to people in exchange for a monthly payment from the state. Private insurance companies may offer health plans for Medicaid recipients and these plans are considered Medicaid MCOs.

Our office participates with the following Medicaid MCOs:

- Virginia Premier
- Virginia Premier Elite Plus

Helping Hands, Inc. **DOES NOT** participate with fee-for-service Medicaid or any other Medicaid MCO.

If your Medicaid MCO changes from Virginia Premier or Virginia Premier Elite Plus during the time in which your child is receiving therapy services to a coverage we do not participate in (such as fee-for-service Medicaid), you acknowledge that you are responsible for the balance owed for services rendered. It is the patients'/parents' responsibility to stay informed as to the status of your coverage, and any changes to your coverage that may occur.

I, _____, have read and understand that Helping Hands, Inc. does not participate with fee-for-service Medicaid.

I, _____, have read and understand the Helping Hands, Inc. Medicaid MCO Policy, and that I will be responsible for any balance owed for services rendered should my child's Medicaid MCO coverage change to a non-participating MCO or fee-for-service Medicaid.

_____ _____

Parent's Signature Date

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HELPING HANDS, INC.
INFORMED CONSENT FOR SERVICE FEES

Evaluation: A typical Speech Therapy evaluation consists of a standardized assessment of receptive & expressive language, as well as speech sound production. Evaluation also assesses the oral mechanism, voice quality and pragmatic language skills. We assess all patients in all areas and do not segment out our assessments regardless of insurance coverage. Any services deemed excluded from your insurance plan may be billed to the patient.

Initial _____

Treatment: I voluntarily consent to treatment/services that are deemed necessary by my referring physician and my occupational therapist. I understand that it is this practice's intent to educate me on every process during my treatment program. I understand that therapy will be rendered for set duration and frequency leading to discharge. I understand that "hands-on" manual or exercise techniques may be used to retrain, recruit, and restore improved postural alignment with treatment, and that if I do not completely understand the process of my treatment, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how she/he is trying to achieve them. I also realize that no guarantees have been made to me as to the results of these services at Helping Hands, Inc. Helping Hands, Inc. will assign patients to a "Primary Therapist" but patients may be seen by any of our therapists as we are a rehabilitative facility and all therapists are licensed and trained to work with all patients.

Initial _____

Observation: All services provided at Helping Hands, Inc. may be recorded or observed. These observations are restricted to individuals who are associated with Helping Hands, Inc., and have completed HIPAA training. Non-identifying information may be used for administrative purposes.

Initial _____

Photos & Videos: Pictures and videos may be made of activities within the practice. These pictures may be used for educational purposes, in Helping Hands, Inc. brochures/presentations, on the Helping Hands, Inc. website, and/or in association with clinic media coverage. Please indicate below your intent to grant permission to use photos of your child as specified above:

Yes _____ No _____

Helping Hands, Inc. will respect the right of privacy of its clients and will hold all recorded sessions and information with strict confidence and will use this information only in rendering of professional services or educational instruction. The contents of your sessions will not be revealed to any person or agency except under the following circumstances:

1. If you, or a legal guardian/parent, give written permission to release the information.
2. If you or your child reveals information which, in your clinician's judgment, indicates that you or your child intends to harm self or someone else.
3. If you or your child reveal information that indicates the existence of past or present abuse of a child, elderly, or disabled adult, as required by Virginia law.
4. If an appropriate court order or subpoena is received.
5. If you or your child is involved in a medical emergency, information may be given to medical personnel.

I, the undersigned, am the parent/legal guardian of the client named below. I have read and understand the above and consent to services for my child and/or family at Helping Hands, Inc.

_____
Printed Name of Parent/Legal Guardian

_____ _____
Signature of Parent/Legal Guardian Date

Client Name: _____ Date of Birth: _____

Patient's Right's & Responsibilities

Patient's Right's

- Access to copies of his/her medical records by written request.
- Quality services appropriate to your condition and delivered on time.
- Any medically necessary treatment.
- Reasonable access to care.
- To be treated with dignity, respect, and concern.
- Complete confidentiality of all medical and financial records.
- Information about your condition as it relates to diagnostic tests, treatment plans and other procedures.
- The ability to change therapists at any time or to request a second opinion within or outside this practice.
- Visual privacy.
- Refusal of treatment or therapy and information regarding the consequences of such a decision.
- Expression of your concerns, complaints, and grievances.
- The right to an itemized statement of billed charges upon request.

Patient's Responsibilities

- Please try to keep all scheduled appointments.
- Please notify us when you are unable to keep a scheduled appointment.
- Feel free to ask questions when you need more information or do not understand.
- Take responsibility for your health. Use this practice in an advisory role when making healthcare decisions.
- Be informed regarding your insurance plan, treatment coverage and benefit rules.
- Obtain any necessary referrals from your primary care physician prior to your appointment.
- Treat our staff with courtesy and dignity.
- Our goal is to provide the best possible care. Please help us in our efforts by reviewing the information in this packet. We encourage you to discuss any concerns or ask any questions when you are in our offices.

Additionally, you may contact our offices about your questions and concerns at any time. Simply call the office and ask to speak to a manager or supervisor. We thank you for choosing our office for your therapy needs.

_____ _____

Signature of Parent/Legal Guardian Date:

Developmental and Medical History for Speech Therapy

_____ _____

Child's name (please print) Informant's name and relation (please print)

Briefly describe why you are pursuing an speech therapy evaluation for your child:

_____

_____

Please circle the answers which best describe your child. Please add any remarks or comments that you feel may be helpful, including your child's strengths. This information is vital to our evaluation process. Your observations give us details about day-to-day life, and so, help us to interpret our test findings with greater accuracy. Thank you for your time.

HOUSEHOLD INFORMATION

Does the child live with both parents? Circle one: YES NO

Parent #1's Name: _____ Age: _____
Parent #1's Occupation: _____Business Phone: _____

Parent #2's Name: _____ Age: _____
Parent #2's Occupation: _____Business Phone: _____

Brothers and Sisters (include names and ages):

_____

_____

What languages does the child speak?

_____

_____

What is the child's dominant language?

_____

_____

What languages are spoken in the home?

_____

_____

What is the dominant language spoken?

_____

_____

With whom does the child spend the most of his or her time?

_____

_____

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CHILD CASE HISTORY FORM

Describe the child's speech language problem.

_____

_____

_____

_____

How does the child usually communicate? (Gestures, single words, short phrases, sentences, etc.)

_____

_____

_____

_____

When was the problem first noticed? By whom?

_____

_____

_____

_____

What do you think may have caused the problem?

_____

_____

_____

_____

Has the problem changed since it was first noticed?

_____

_____

_____

_____

Is the child aware of the problem? If yes, how does he or she feel about it?

_____

_____

_____

_____

Have any other speech-language specialists seen the child? Who and when? What were their conclusions or suggestions?

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_____

_____

_____

_____

Have any other specialists (physicians, audiologists, psychologists, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

_____

_____

_____

_____

Are there any other speech, language, or hearing problems in your family? If yes, please describe.

_____

_____

_____

_____

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PRENATAL AND BIRTH HISTORY - BEFORE BIRTH		
1. Were there any illnesses, injuries, fainting spells, bleeding, anemia, operations, or any other medical difficulties?	YES NO	Remarks:
2. Were there any drugs, medications, alcohol, or cigarettes used during pregnancy?	YES NO	Remarks:
3. If adopted, provide the date and age when the child arrived at your home. Please specify any known details of care before adoption.	DATE _____ AGE _____	Remarks:
PRENATAL AND BIRTH HISTORY - DELIVERY		
1. Was the delivery premature?	YES NO	Remarks:
2. Was medication given to induce labor or given during labor? Please specify.	YES NO	Remarks:
3. Was the labor abnormal? (ie. Prolonged, short, etc.?) Please specify.	YES NO	Remarks:
4. Was it an unusual delivery? (ie. Breech, Caesarean, forceps, etc.) Please specify.	YES NO	Remarks:
5. What was the baby's gestational age (in weeks) and birth weight?	AGE: _____ (weeks) WEIGHT: _____ lbs. & oz.	Remarks:
PRENATAL AND BIRTH HISTORY - BIRTH		
1. Was the baby alert with normal muscle tone and color at birth?	YES NO	Remarks:
2. Were there medical complications at birth affecting heart, lungs, kidney, or digestive organs? Please explain.	YES NO	Remarks:
3. Were there any congenital defects affecting the limbs, face, nerves, and/or other body parts? Please explain.	YES NO	Remarks:
4. Were there complications such as cyanosis, jaundice, or limpness? Please specify.	YES NO	Remarks:
5. Was there a need for oxygen, transfusions, IV, or tube feedings?	YES NO	Remarks:
6. Did the baby spend extra time at the hospital or time in a special nursery?	YES NO	Remarks:
7. Was the baby bottle or breast-fed? Please circle.	BOTTLE BREAST-FED	Remarks:
8. Were there any feeding complications? Please specify.	YES NO	Remarks:
MEDICAL HISTORY SINCE NEWBORN PERIOD		
1. Are your child's immunizations up to date for the following: a. Measles, Mumps, & Rubella b. Chicken Pox c. Diphtheria, Pertussis, & Tetanus d. Polio e. Hepatitis B	 YES NO YES NO YES NO YES NO YES NO	Remarks:
2. Describe any significant adverse reaction to vaccines.		Remarks:

3. Circle any serious illnesses (s)he has had and give dates and current status. a. Meningitis b. High Fevers c. Scarlet Fever d. Diabetes e. Seizures (dates, how often, type?) f. Respiratory, stomach, kidney, liver, or heart problems g. Any allergies (please specify) h. Tuberculosis i. Polio j. Physical Injuries k. Malnutrition l. Frequent Ear Infections/Tubes m. Surgeries n. Others, please list:	Dates: a. _____ b. _____ c. _____ d. _____ e. _____ f. _____ g. _____ h. _____ i. _____ j. _____ k. _____ l. _____ m. _____ n. _____	Remarks:
4. Has your child had vision and hearing exams? Circle and list dates, by whom, and results. a. Vision b. Hearing	Dates: a. _____ b. _____	Remarks:
5. Is your child currently on medication? Please give names and reasons.	YES NO	Names and Reasons:

DEVELOPMENTAL HISTORY

At what ages did your child meet these motor milestones? Please note those that were skipped or not yet achieved.	Age:	Comments/Clarifications:
1. Sit independently	1. _____	
2. Crawl on hands and knees	2. _____	
3. Cruise around furniture	3. _____	
4. Walk independently	4. _____	
5. Drink from a cup without a lid	5. _____	
independently	6. _____	
6. Use a spoon independently	7. _____	
7. Put on shirt independently		
8. Button independently	8. _____	
9. Dress independently	9. _____	
10. Use toilet independently	10. _____	
11. Use single words (e.g., no, mom,	11. _____	
doggie)		
12. Combine words (e.g., me go,	12. _____	
daddy shoe)		
13. Name simple objects (e.g., dog,	13. _____	
car, tree)		
14. Use simple questions (e.g.,	14. _____	
Where's doggie?)		
15. Engage in a conversation	15. _____	

Does the child have difficulty walking, running, or participating in other activities that require small or large muscle coordination?

_____

_____

Are there or have there ever been any feeding problems? (e.g., problems with sucking, swallowing, drooling, chewing) If so, please describe.

_____

_____

Describe the child's response to sound. (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds)

_____

_____

EDUCATIONAL HISTORY

School: _____ **Grade:** _____
Teacher(s): _____

How is the child doing academically (or pre-academically)?

_____
_____

Does the child receive special services? If yes, describe.

_____
_____

How does the child interact with others? (e.g., shy, aggressive, uncooperative)

_____
_____

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? If yes, describe some of the goals.

_____
_____

Provide any additional information that might be helpful in the evaluation or remediation of the child's problem.

_____
_____

Additional information that would help us to better understand your child:

_____
_____
_____
_____
_____

Do not leave any blank spaces. If the question/item does not pertain to your child, please indicate "N/A" (Not Applicable).

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