

# Communication Innovations

● ● ● PROVIDING PT, OT & SPEECH SERVICES

2990 Cahill Main  
Suite 204  
Madison, WI 53711

P 608.204.6083  
F 608.204.6183

[www.communicationinnovations.com](http://www.communicationinnovations.com)

Thank you for your interest in Communication Innovations!

Please complete this form and all of the enclosed paperwork. This must be returned to Communication Innovations no less than 2 weeks prior to your evaluation time. We are excited to be part of your child's growth and development.

Reason for evaluation: \_\_\_\_\_

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Parent's intended outcome \_\_\_\_\_

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-----Internal use only-----

Date of eval \_\_\_\_\_

Evaluator \_\_\_\_\_

Tx date \_\_\_\_\_

Notes

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## PATIENT INTAKE FORM

Section I:	Patient Information	Date _____
Name: _____	Nickname: _____	
Address: _____	City: _____	State: _____ Zip _____
Phone (_____) _____	Work Phone (_____) _____	Cell Phone (_____) _____
Email Address _____		
Date of Birth: _____	Social Security Number: _____	
If Student, Name of School _____	City/State _____	
Spouse or Parent's Name: _____	Employer _____	Work Phone _____
Whom may we thank for referring you? _____		
Person to contact in case of emergency _____	Phone _____	

Section II	Responsible Parties
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name: _____	Relationship to Patient: _____
Address: _____	
City: _____	State: _____ Zip: _____ Phone: (_____) _____
Employer _____	Work # (_____) _____ Cell #(_____) _____
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name: _____	Relationship to Patient: _____
Address: _____	
City: _____	State: _____ Zip: _____ Phone: (_____) _____
Employer _____	Work # (_____) _____ Cell #(_____) _____

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## Section III

## Insurance Information

Name of Insured \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

SSN#: \_\_\_\_\_ Name of Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Address of Employer: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Grp # \_\_\_\_\_ ID# \_\_\_\_\_

Ins Co Address: \_\_\_\_\_ Ins Co. Phone: \_\_\_\_\_

I hereby authorize Communication Innovations, Inc to furnish information to the aforementioned insurance carrier(s). I authorize insurance benefits to be aid directly to the provider by my indicated insurance company(s). I understand that as the patient I am responsible for the fees accrued.

Signature \_\_\_\_\_ Date \_\_\_\_\_

----- DO YOU HAVE ANY ADDITIONAL INSURANCE?  Yes  No IF YES, COMPLETE THE FOLLOWING -----

Name of Insured \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

SSN#: \_\_\_\_\_ Name of Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Address of Employer: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Grp # \_\_\_\_\_ ID# \_\_\_\_\_

Ins Co Address: \_\_\_\_\_ Ins Co. Phone: \_\_\_\_\_

## Case History

### Section IV:

### Problem History

Please describe the problem(s) you would like to address:

When was the problem(s) initially noticed?

Please describe any previous treatment(s):

## Section V: General Development

Pregnancy & birth history: Did any illnesses or accidents occur during pregnancy? If so, please explain.

Were there any unusual problems at birth? If so, please explain.

DEVELOPMENT: At what age did the following milestones occur?

Head Control: \_\_\_\_\_ Rolling: \_\_\_\_\_ Unsupported Sitting: \_\_\_\_\_

Crawling: \_\_\_\_\_ Walking: \_\_\_\_\_ Toilet Trained: \_\_\_\_\_

First Words: \_\_\_\_\_ Fed Self w/ spoon: \_\_\_\_\_

## Section VI: Medical History

Please list any illnesses, operations, or difficulties that have occurred. Please include age, frequency, severity and method of treatment(s).

Is your child currently under the care of a physician? If so, for what reason(s)?

Has your child's vision or hearing been examined recently? If so, what were the results?

Does your child have any allergies (i.e. gluten, soy, bee stings, medications, etc.)

Please list any medications your child is currently taking.

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## Section VI cont.

## Medical Contacts

**1. Pediatrician or General Practice Dr.:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**2. Orthopedist :** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**3. Neurologist :** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**4. Therapy Clinic for PT/ST/OT :** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**5. Additional Healthcare Provider:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

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## Section VII: Family History

Do any speech, fine motor, or gross motor problems exist on either side of the family? Please explain.

List any problems that are observed in the school/work environment:

List any syndromes, delays or diagnoses:

## Section VIII Educational History

Current School: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Is your child frequently absent from school? If so, why?

How does your child feel about school and his/her teachers?

Does your child receive any special services from the school district? If so, please explain.

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## Speech/Language

Please describe any specific needs related to your child's speech, language, and communication skills (i.e. talking, following directions, expression, articulation etc.)

## Fine Motor

Please describe any specific needs related to your child's fine motor skills (i.e. writing, cutting, etc.)

## Gross Motor

Please describe any specific needs related to your child's gross motor skills (i.e. walking, sitting, jumping, etc.).

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## Reading/ Writing/Education

Please describe any specific needs related to your child's academic skills.

## Additional Information

Please provide any additional information that you feel is relevant to proper evaluation and treatment of your child.

## Child's Size Information

Shoe Size without AFOs : \_\_\_\_\_

Shoe Size with AFOs : \_\_\_\_\_

Height : \_\_\_\_\_

Weight : \_\_\_\_\_

Clothing Size : \_\_\_\_\_

Chest Measurement : \_\_\_\_\_

Waist Measurement : \_\_\_\_\_

Hip Measurement : \_\_\_\_\_

-----For internal use-----

Color of Suit Top: \_\_\_\_\_

Color of Suit Bottom: \_\_\_\_\_

Notes:

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## Standard Photo Release

Communication Innovations maintains a website and prints published material which can include photographs and video of patient and/or patient's family while attending therapy sessions. Inclusion in the website and print material is strictly voluntary and is not paid for, endorsed or compensated in any way.

To enable us to include your child/dependent in our website or print material, we require your signature.

Thank you!

I \_\_\_\_\_ (print name), being the parent or guardian of \_\_\_\_\_ (print patient's name) do hereby give full permission to Communication Innovations, its employees, staff, volunteers, etc. to use photographs, video and/or written information of my child/dependent in the Communication Innovations website and/or any printed materials.

I waive any right I have to inspect and approve the finished product or copy that may be used.

I affirm that I am over the age of 18-years-old and/or the parent/guardian of the above-mentioned patient.

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Signature of Parent or Legal Guardian or patient if 18 years or older

---

Date

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## FINANCIAL POLICY

Effective January 1st, 2010

Welcome to Communication Innovations, Inc. We are committed to providing top quality therapy services to you and your family. Please read the following information carefully. Payment for your services is part of your treatment; below is a statement of the Communication Innovation, Inc. financial policy.

We are happy to accept payment through your personal insurance company. We DO NOT accept Medicaid or Medicare at this time. Please understand that your insurance policy is a contract between you and your insurance carrier. Communication Innovations, Inc. is not a party to that contract. We suggest that you contact your insurance company directly to determine if your specific carrier covers your specific therapy at Communication Innovations, Inc. Please be aware that some or perhaps all of the services provided by Communication Innovations, Inc. may not be covered under your insurance policy. Any outstanding insurance balance will be transferred to the patient payment portion after 120 days of services rendered.

Many insurance companies place limitations on the number of visits, reason for visits, medical necessity, and a myriad of other factors. Communication Innovations is not responsible for insurance denials of any reason. We are happy to work with your insurance company and to gather information. However, we do not guarantee coverage and strongly encourage each family to contact their insurance carrier directly to verify coverage.

Our practice is committed to providing the latest and most effective treatments for our patients and their families. We charge what is usual and customary for services in our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary, or denial of claim for any reason. All out of office sessions will be charged a minimum of one hour and charged accordingly to include travel and preparation time.

Payment is due in full 45 days from the billing date or is subject to a \$20 monthly charge. Insurance payments received past the 45 day time frame will be reimbursed to you or posted to your account. We DO accept credit cards. Many families leave a credit card on file for monthly charges.

Because our programs continue to expand, scheduling has become increasingly more difficult. In order to better meet the needs of our patients we would like to remind you that a "no-show" appointment, for any reason, is subject to a 100% charge of the therapy fee. Any appointment cancelled less than 24 hours in advance is subject to a \$50 per hour charge. However, we do understand that children get sick and unfortunate circumstances arise. Thank you for your understanding and for providing advance notice for any cancelled appointments!!

**Intensive Therapy:** The intensive PT and OT method is a specialized program that requires specific training, scheduling, and equipment. We are pleased to offer this program! It is in very high demand and requires a \$1000.00 non-refundable down payment to hold your spot. Full payment is due 1 week prior to start date. Patients will be scheduled for 3 or 4 weeks of consecutive treatments, which is important for the quality and success of therapy. If you miss a scheduled therapy session for any reason, we will attempt to make it up at the end of your session if schedules and time allow. Please be aware that this is not always an option as other families have scheduled the time and equipment as well. Thank you for your understanding. Therapy sessions run for 4 consecutive hours. If the session is cut short by the family, it will be marked as a full session.

**Aquatic Therapy:** This program is scheduled in 8 week increments. In registering for this program, you are registering for a minimum of 8 weeks. If you have a scheduling conflict that you are already aware of, please let your therapist know so other arrangements can be made. We are excited to be using the wonderful facilities at

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Swim West. If you need to cancel an appointment for any reason, please understand that this appointment MUST be rescheduled within the same week if scheduling allows.

## HOURLY RATES:

Assessment/Evaluations-- \$200.00\*\*

Speech Therapy--\$130.00

Occupational Therapy--\$130.00

Physical Therapy--\$130.00

Aquatic Therapy-- \$130.00

Reading/ Math Support--\$50.00 - \$70.00

ECE Augmentation--\$35.00

(All of the above therapies are individual sessions. Rates are calculated considering a one to one ratio. If an additional therapist is required an additional \$30 fee will be charged.)

## Our Group Rates:

Social Groups--\$35.00 per hour

Motor Groups--\$35.00 per hour

Adult Social Groups-- \$40.00 per hour

**Auditory Integration Training--\$1000.00**

## **Fast ForWord- Language / Literacy**

In Clinic- \$2200.00

At Home- \$1800.00

## **Fast ForWord- Reading**

In Clinic- \$1800.00

At Home- \$1600.00

## **Intensive Therapy Program:**

3 Week Session--\$7200.00

\*\* assessments may exceed 1 hour in time and will be charged accordingly. Documentation time is not charged

\*additional fees may be charged for special outings. If patient attends 3 or more individual sessions group fees are waived.

I have read and understand the Policy of Communication Innovations, Inc.

Signed \_\_\_\_\_ Date \_\_\_\_\_

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## Consent for Participation / Informed Consent Waiver for:

**Occupational Therapy / Physical Therapy / Speech Therapy / Social Groups / Motor Groups / Let's Play / AIT / Interactive Metronome / Fast ForWord / Aquatic Therapy / Handwriting Without Tears / Tutoring / Music Therapy / Early Childhood Education Augmentation/ Intensive Therapy/ Therasuit**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

I \_\_\_\_\_

Signature of: Patient or Parent / Guardian

Hereby release Communication Innovations owners and employees from any liability, claims, demands and causes of action, now or in the future, resulting from injury or accident however caused, occurring during any type of therapy or activities at Communication Innovations.

In signing this Consent for Participation/Informed Consent Waiver, I have fully read the above statement. I give my permission for my child to participate in all activities provided by Communication Innovations and their staff. This will include off site activities (example: social group field trips).

**The following forms are to be completed by you / your child's physician.**

**Please remember that we require hip and spine x-rays that are NOT older than 6months from the start of therapy!**

#### Hip and Spine X-Ray Clearance

Prior to the beginning of your child's Therasuit Session, we will need medical clearance from your child's physician indicating that your child does not have hip subluxation or scoliosis. This can be obtained through an A/P hip x-ray and a spine x-ray and should be completed no more than 6 months prior to the start of your child's intensive therapy session.

With Therasuit Therapy, we load both the hips and spine using elastic cords on the suit which causes an increase in forces through the hips and spine. We do not want to cause any increased pain or injury to your child if these conditions exist.

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## **Letter of Medical Clearance for Intensive Therapy**

Dear Medical Physician,

This letter is to inform you that your patient, \_\_\_\_\_ is scheduled to attend Communication Innovations' Intensive Pediatric Therapy Program in Madison, WI. The intensive program consists of physical therapy and occupational therapy services for up to 4 hours daily, 5 days per week, for a period of 3 to 4 weeks. Your patient may also be receiving speech and language therapy services in addition to the aforementioned daily PT and OT services.

The program consists of intensive therapeutic exercises that will increase blood pressure, increase heart rate and increase respiration rate. If your patient is a candidate, the Therasuit may be used. The Therasuit is comprised of a vest, shorts, kneepads, elbow pads, and shoes that are connected with bungee type cords to correctly align the body. The suit forms an "exoskeleton" on the body providing pressure to the joints of the body ranging from 10 to 40 pounds. The patient is then put through a series of exercises, developmental sequences, and motor planning activities to strengthen the muscles and retrain the body.

We appreciate you taking the time to review this information. It is necessary for us to effectively treat your patient while he/she is at Communication Innovations. If you have additional questions or concerns please contact the director of therapy at 608.204.6083.

**Please fill out the following form and write a prescription for**

**"OT/PT/Speech evaluation and treatment for INTENSIVE THERPY session at Communication Innovations"**

If the Therasuit is utilized, the child will need recent bilateral hip x-ray and spine reports, less than 6 months old, mailed to our office 30 days before treatment. The actual x-rays are not necessary but the percent of subluxation or degree of spinal curve is required.

Sincerely,

The Communication Innovations Team

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Patient name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Physician's name: \_\_\_\_\_

Physician's address: \_\_\_\_\_

\_\_\_\_\_

Physician's phone: \_\_\_\_\_

## **Please review the following conditions and check any/all that apply:**

Cardiac conditions: \_\_\_\_\_ if yes, please explain \_\_\_\_\_

High blood pressure: \_\_\_\_\_

Shunt: \_\_\_\_\_

History of fractures: \_\_\_\_\_

Bone conditions: \_\_\_\_\_

Hip subluxations: \_\_\_\_\_

Please write degree of hip subluxation for: Right \_\_\_\_\_ Left \_\_\_\_\_

- Please provide x-ray report if any subluxation is present

Would you recommend a bone density test prior to an intensive therapy session? \_\_\_\_\_

Seizures: \_\_\_\_\_

Are they controlled by medicine: \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

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Respiratory conditions: \_\_\_\_\_

Scoliosis: \_\_\_\_\_ Degree of curvature: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Kidney problems: \_\_\_\_\_

Any other conditions not mentioned in which precautions need to be taken or would make intensive therapy contraindicated?

\_\_\_\_\_

I would \_\_\_\_/would not \_\_\_\_ recommend this patient for your program.

\_\_\_\_\_

Physician's Signature

Date

\_\_\_\_\_

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## Prescription

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Diagnosis \_\_\_\_\_

Therapy Recommended:

Physical Therapy

Occupational Therapy

Speech Therapy

Aquatic Therapy

Intensive PT/OT program

(5 times a week, evaluation and treatment)

Evaluation Only

Evaluation and Treatment

Additional Comments or Concerns:

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Physician Name

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Physician Signature