Communication Innovations

PROVIDING PT, OT & SPEECH SERVICES

2990 Cahill Main
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P 608.204.6083
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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: ____________________________________

____

____

____

____

Parent's intended outcome _________________________________

____

____

____

____

____

---------------------------------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: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:____ Relationship to Patient: ____________________

Address:____

City:______________________________ State:_________ Zip:____________ Phone: (____)___________________

Employer_______________________ Work # (____)________________ Cell #(____)_____________________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ 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:______________________________

------------ DO YOU HAVE ANY ADDIONAL 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 VI: **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):

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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?

Crawling _______________ Toilet Trained _______________ Walking_______________

Sat Unsupported_______________ First Words _______________ Fed Self w/ spoon___________

Section IV **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.)

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: __________________________

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.

Speech/Language

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

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.

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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 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 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.

____

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

____

Date

FINANCIAL POLICY

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Effective January 15th, 2009

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.

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.

Payment is due in full 45 days from the billing date or is subject to a $15 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.

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 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--$120.00

Occupational Therapy--$130.00

Our Group Rates:

Social Groups--$35.00 per hour

Motor Groups--$35.00 per hour

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** 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).

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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 eval and treat for intensive therapy session"

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: ___________

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

____

Physician Name

____

Physician Signature

____

Date