

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

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 24 hours 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 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 _____

Please list **ALLERGIES, DIET RESTRICTIONS, and MEDICAL CONCERNS**

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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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 release medical information to the aforementioned insurance carrier(s).

Signature _____ **Date** _____

I authorize insurance benefits to be paid directly to the provider by my indicated insurance company(s). I understand that some or all services may not be covered by my insurance carrier. I understand that denied services (for any reason) coinsurance, deductibles and non-reimbursable items (missed appointments, reports, travel time) are my financial responsibility. I understand that the parent/guardian is responsible for all fees owed to Communication Innovations.

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: _____

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Case History

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

When was the concern(s) initially noticed?

Please describe any previous treatment(s):

General Development

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

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

DEVELOPMENT: Have the following milestones been met? Please indicate at what age.

Head Control: _____ Rolling: _____ Unsupported Sitting: _____

Crawling: _____ Walking: _____ Toilet Trained: _____

First Words: _____ Fed Self w/ spoon: _____

Medical History

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

Event 1 :

Event 2:

Event 3:

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Is your child currently under the care of a physician/therapist? 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.

Family History

Who does patient reside with? Please include sibling names and ages.

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

List any syndromes, delays or diagnoses:

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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.)

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Fine Motor

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

Sensory

Please describe any specific needs related to your sensory skills (i.e. auditory, tactile, seeking behaviors, defensiveness, 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.

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

Additional Information

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

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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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Standard Photo Release

Patient Name: _____

Communication Innovations, Inc. 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, being the parent or guardian of the above names patient, 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 have read the above Photo Release and agree to abide by the above policies.

X _____
Signature of Parent/Guardian Date

Consent for Participation / Informed Consent Waiver for Participation

Patient Name: _____

I 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.

I understand that there is some inherent risk in the use of therapy equipment at Communication Innovations, Inc. I agree to indemnify and hold Communication Innovations, Inc harmless from any and all losses and claims for any injuries or damages occurring to myself, my child, or my belongings from the use of therapeutic equipment.

I understand that Communication Innovations has food and snacks present. I understand that my child may come in contact with food, and monitoring of allergies and reactions is my responsibility. While Communication Innovations will work with me and my dietary needs, Communication Innovations will be held harmless for allergic reactions and food related injury.

I understand that if an emergency medical situation should arise, and I am not on site, the staff at Communication Innovations will make choices and determinations that they feel are in the best interest of the child. I will hold Communication Innovations, Inc harmless for decisions made in the best interest of my child.

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).

I have read the Consent for Participation and agree to the above terms and policies.

X _____
Signature of Parent/Guardian Date

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NOTICE OF FINANCIAL RESPONSIBILITY/ FINANCIAL POLICY

Updated May 1, 2011

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.

INSURANCE INFORMATION

*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.

*Communication Innovations has contracts with many insurance companies. Please contact our office and your insurance company to determine the status of your specific carrier. It is the patient/parent's responsibility to fully understand the benefits, limits, and exclusions of your specific policy.

*All parents are expected to know and understand their coverage and benefits for therapy services. It is very important that you ask specifically about any "exclusions" or "limitations" to therapy benefits. A quote of benefits from your insurance company is not a guarantee of payment. In the event your insurance chooses not to pay for services, you are ultimately responsible for all charges.

*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 balance left unpaid by insurance company after 60 days, is the responsibility of the client. At this time, if payment is not made immediately, services may be placed on hold until the balance is paid in full.

*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. The parent/caregiver is ultimately responsible for any payments from past, current, or future services rendered. All out of office sessions will be charged a minimum of one hour and charged accordingly.

*Insurance companies use procedure codes to process your claim. These codes are referred to as units. Some insurance companies have limits on the number of units they will pay per visit

*Please provide Communication Innovations, Inc. with a copy of your insurance card each time you receive a new card and/or your insurance information changes. Please understand that if your insurance company delays payment or is waiting on additional information before they render payment, and the balance due is past 60 days, the balance is your responsibility and is due immediately.

*We will do our best to answer any insurance related questions. However, calling your insurance company directly is frequently required. Any follow-up regarding non-payment after our initial appeals process is your responsibility. **If payment is not issued by the insurance company within 60 days of initial filing, you are responsible for payment IN FULL for all services rendered. It is then your responsibility to follow up with the insurance company regarding any further appeals.**

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ADDITIONAL INFORMATION

*If we are not filing insurance for you, services will be billed to you at the end of the month. Payment is due within 30 days or is subject to a \$20 per month late fee.

*Our therapy sessions run for 55 minutes of direct treatment time. This allows for transition time to/from treatment and clean up time.

*Please allow our therapists ample notice of outside meetings and consultations. This includes IEP meetings, school visits, home visits, etc. Patients will be billed the hourly rate plus travel time to/from the appointment. All scheduling should go through the CI office.

* If you must cancel an appointment, please do so by giving 24 hours notice. We do encourage rescheduling your appointment if possible. It is essential to keep a regular schedule for any treatment to be successful.

* Understanding that emergencies do occur, it is our policy that any **cancellation with less than 3 hours notice** will result in a charge of **\$50.00**. These charges are not reimbursable by your insurance company and must be paid at the time of your next bill.

*You will be notified as far in advance as possible when your therapist is ill, on vacation or attending a continuing education conference. Every effort will be made to reschedule your appointments so that your child will miss as little treatment as possible.

*If you choose to leave the center during your child's therapy appointment, please be prompt in picking up him/her when the session is over as we do not have means for childcare. Please leave all current contact information in case of any emergencies with your therapist or our front office staff upon leaving. Late pick-up is subject to a charge of \$25.

INTENSIVE PT/OT

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.

I have read and understand the Financial Policy of Communication Innovations, Inc. I agree to abide by these policies.

X _____

Signature of Parent/Guardian

_____ Date

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Authorization for Disclosure of Health Information

Patient Name: _____
Parent/Guardian's Name _____

Date of Birth: _____
Date : _____

I authorize the use or disclosure of the above named individual's health information as described below.

The following individual or organization is authorized to make the disclosure or receive disclosure from agencies:

COMMUNICATION INNOVATIONS< INC 2990 Cahill Main, Suite 204. Fitchburg, WI 53711

The type and amount of information to be used or disclosed is as follows: (please check).

_____ Complete Treatment Records

_____ IEP Reports

_____ Phone Consultation

_____ Other (please specify):

This information may be disclosed to/ received from the following individual or organization.

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

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 revoked 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 assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules

Signature of patient or legal representative

Date

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, par

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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:

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:

Physician Name

Physician Signature