TPI Therapeutic Potentials, Inc.

Patient Information

PATIENT: ______________________ BIRTHDATE: ______________ AGE: ____

SOCIAL SECURITY #: ______________________ MEDICAID #: ______________________

ADDRESS: ____

STATE, CITY, ZIP: ____

PHONE #1: ______________________ PHONE #2: ______________________

GUARDIAN#1: ______________________ RELATIONSHIP: ______________________

SOCIAL SECURITY #: ______________________ BIRTHDATE: ______________________

ADDRESS: ____

STATE, CITY, ZIP: ____

PHONE #1: ______________________ PHONE #2: ______________________

GUARDIAN#2: ______________________ RELATIONSHIP: ______________________

SOCIAL SECURITY #: ______________________ BIRTHDATE: ______________________

ADDRESS: ____

STATE, CITY, ZIP: ____

PHONE #1: ______________________ PHONE #2: ______________________

EMERGENCY CONTACT PERSON: ____

PHONE #1: ______________________ PHONE #2: ______________________

PHYSICIAN: ______________________ FACILITY: ______________________

ADDRESS: ____

STATE, CITY, ZIP: ____

PHONE: ______________________ FAX: ______________________

EMAIL: ____

REFERRAL SOURCE: ____

INSURANCE INFORMATION

Please Attach a Copy of Insurance Card
Front and Back

PRIMARY INSURED ______________________________DOB__________APPT DATE_________

INSURANCE CO. ___________________________ PHONE NO. _______________________

ID NUMBER _______________________ GROUP NUMBER ______________________________

EMPLOYER ____

Office Use Only Below Line

Benefits Verified with ___________________ on _________, 20__ @ _____ AM/PM

Effective Date ____________ Pre-Ex: Y N Cert of Creditable Coverage Y N

Audit/Confirmation Number: ____

PCP/Referring MD Name/Phone____

ST THERAPY BENEFITS: In Network Out of Network

Deductible ($)___________Met ($) ___________ Required Docs ________________

Auth Y N Phone for Authorizations ________________ Fax_______________

Visit # _________or Limit $________ *Available* Visits _______or Limit $_____ *Used*

__________% Coinsurance *OR* Co-pay $ _______ per Visit Day

Disclaimers/Other Info:

OT THERAPY BENEFITS: In Network Out of Network

Deductible ($)___________Met ($) ___________ Required Docs ________________

Auth Y N Phone for Authorizations ________________ Fax_______________

Visit # _________or Limit $________ *Available* Visits _______or Limit $_____ *Used*

__________% Coinsurance *OR* Co-pay $ _______ per Visit Day

Disclaimers/Other Info:

Consent to Treatment Form

PATIENT'S NAME: ____

CONSENT TO MEDICAL TREATMENT

I, the undersigned, whether acting as agent or patient, voluntarily consent to therapy as determined to be necessary or beneficial in the professional

judgment of my physician or therapist. I acknowledge that no guarantees have been made to me as to the affect of such treatment on my condition.

CONSENT FOR RELEASE OF MEDICAL INFORMATION:

I, the undersigned, whether acting as agent or patient, consent to the release of my medical records to my doctor and to my insurance company.

FINANCIAL AGREEMENT:
I, the undersigned, whether acting as agent or patient, agree that in consideration for the services rendered or to be rendered do hereby

assign payment directly to Therapeutic Potentials, Inc. I hereby agree to pay any and all charges that exceed or that are not covered by my insurance.

This assignment is irrevocable.

This document has been fully explained to me and I certify that I understand its comments and agree to it freely, and that I am the patient or

I am duly authorized as the patient's agent or representative to execute the above.

______________________________________ ____
Patient or Patient's Agent/Representative Date

______________________________________ ____
Print Name of Signature Above If Patient's Agent/Representative (Describe relationship)

______________________________________ ____
Witness Date

Office Policy

Payment is expected at the time services are rendered. We will provide the necessary information for you to file at the time of service.

Brief conferences as well as brief telephone conferences are considered part of the regular intervention program, and no additional charges will be made. There will be a charge for conferences with parents, physicians, tutors, or teachers that exceed 10 minutes in length.

If you must cancel a scheduled appointment, it is necessary that you give 24 hour advance notice. Except in the case of emergency or sudden illness, and except for Medicaid clients, appointments that are not cancelled with a 24 hour advance notice will be charged as session was held. Medicaid patients who miss three scheduled appointments without a 24 hour advance notice (except in cases of emergency or sudden illness) will become ineligible to receive further services from Therapeutic Potentials, Inc.

At various times of the year, your therapist may be away from the office. You will be notified in advance of the dates and a make-up session will be scheduled or a substitute therapist will be offered.

I have read and accept the policies of Therapeutic Potentials, Inc. . I authorize Therapeutic Potentials, Inc. to provide evaluation and therapeutic services for:

____
Patient's Name

If I am responsible for any payments or co-payments, I agree to pay such fees at the time services are rendered. In the case that legal action is instituted to collect such fees due to failure to pay on my part, I agree to pay in addition to the costs and disbursements provided by statue such sum as the court may adjudge reasonable as attorneys fees in said action.

____ __________________________
Signature (Client, parent, guardian, responsible party) Date

Illness Policy

An illness policy is important in order to reduce the spread of illness within our clinic. We want to provide consistent services to the

patient, however, if they are ill please keep them at home for 24 hours after the symptoms have disappeared.

Please do not attend therapy if the following symptoms occurred during the past 24 hours:

-FEVER
-VOMMITING
-DIARRHEA
-CONSTANT RUNNY NOSE (allergies not included)
-HEAD LICE
-RASH (if you have a doctor's note indicating that your rash is not contagious, you may attend therapy)

I have read and accept this policy:

____ ____________________
Signature (Client, parent, guardian, responsible party) Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOR MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect __4/14/2003____, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy or our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURE OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at anytime. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights Section of the notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved With Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up therapeutic tools or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Patient Copy Please Keep

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $_____ for each page for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail)), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns please contact us.

If you are concerned that we may have violated your privacy rights, or your disagree with a decision we made about access to your health information or in response to a request your made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of you health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Ray Colombo

Telephone: 941-758-3140 Fax: 941-870-4891

E-mail: RColombo@TPIKids.com

Address: 14415 SR 70 East Lakewood Ranch, FL 34202

Patient Copy Please Keep

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement

I ____ , have received a copy of this office's notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

Therapeutic Potentials, Inc.

Authorization for Release of Information

I,_______________________________, authorize Therapeutic Potentials, Inc. to
(guardian)

exchange information regarding _________________________________ with
(patient)

the following professionals:

Please print names and phone.

Educators____

Caregivers____

Physicians____

Speech Language Pathologist____

Occupational Therapist____

Physical Therapist____

Psychologists____

Other____

Other____

Other____

___________________________________ ______________________________
Signature (guardian) Date

___________________________________ ______________________________
Print Name of Signature Describe Relationship

Patient History

NATURE OF PROBLEM

Describe your child's speech, language, fine motor, gross motor and/or learning difficulties.

____

____

____

When was it first noticed?

____

____

____

BIRTH HISTORY

Did the mother have any accidents, illnesses, or other unusual complications during pregnancy? Yes No

If yes, please explain. ____

____

Was medication used during labor or delivery? Yes No

If yes, please explain. ____

____

Age of mother at child's birth ________ Length of pregnancy ____________

Birth weight of child ________________

CONDITIONS IMMEDIATELY FOLLOWING BIRTH

Was your baby incubated? Yes No If yes, for how long? ____________

Did your infant have difficulties breathing? Yes No

Was your infant given oxygen? Yes No

Was your infant jaundiced? Yes No

Did your infant have any of the following? Swallowing difficulties ______ Feeding problems_____

Seizures______ Sores or bruises ______ Cleft lip or palate ______

Was birth weight regained quickly? Yes No

MEDICAL HISTORY

Check the illness your child has had and the child's age at the time of the illness:

_____Mumps_____ _____Chicken Pox_____ _____Small Pox_____

_____Tonsillitis_____ _____Asthma_____ _____Influenza_____

_____Tuberculosis_____ _____Convulsions_____ _____Allergies_____

_____Frequent colds_____ _____Epilepsy_____ _____Encephalitis____

_____High Fever_____ _____Whooping cough_____ _____Scarlet fever_____

_____Pneumonia_____ _____Hay Fever_____ _____Measles_____

_____Chronic ear infections____ _____Appendicitis_____ _____Polio_____

_____Lead Poisoning_____ _____Head Injury_____ _____Meningitis_____

_____ Reflux_____ _____Autism SpectrumDis._____ _____ADHD/ADD_____

_____Feeding/Swallowing Difficulties_____ _____Other_____

____

Were any of the illnesses listed above followed by a noticeable change in your child's behavior, speech, language and/or hearing abilities? Yes No

If yes, please explain. ____

____

Was your child ever hospitalized? Yes No How long? ____________________________

If yes, please explain. ____

____

Has your child ever had any severe accidents? Yes No

If yes, please explain. ____

____

Is your child currently taking any medications? Yes No

If yes, please list. ____

____

Does your child have any known allergies? Yes No

If yes, please explain. ____

____

PREVIOUS EXAMINATIONS AND TREATMENTS
(Please indicate when, where, and by whom.)

Speech-Language Evaluation/Therapy____

____

Occupational Evaluation/Therapy____

____

Hearing Evaluation____

____

Ear, Nose and Throat____

____

Neurological____

____

Psycological____

____

Educational____

DEVELOPMENTAL MILESTONES

Please indicate at what age your child developed the following skills.

_____Crawl _____Walk _____First word

_____Combined words _____Toilet trained _____Sit

SPEECH

Can you understand your child's speech? Always Sometimes Rarely

Do others have difficulties understanding your child's speech? Always Sometimes Rarely

Does your child have difficulties producing certain sounds? Yes No

Does your child repeat sounds or words and/or appear to stutter when speaking? Yes No

Is his/her speech accompanied by unpleasant movements or facial expressions? Yes No

VOICE

Does your child's voice sound? High Low Soft Loud

Is the child's voice hoarse? Yes No

LANGUAGE

Does your child seem to understand directions/commands? Always Sometimes Never

Does your child seem to ignore instructions or appear to be confused? Always Sometimes Never

Does your child initiate talk? Always Sometimes Never

Does your child respond to others talk? Always Sometimes Never

Does your child comment on daily activities? Always Sometimes Never

Does your child talk to request needs and wants? Always Sometimes Never

Does your child answer questions? Always Sometimes Never

VOCABULARY

How many words does your child use? _____

Does your child use: Single Words Two to Three Word Combinations Sentences

SOCIAL / PLAY

Does your child respond to others in his/her environment? Always Sometimes Never

Does your child play with others? Always Sometimes Never

Does your child initiate contact with others? Always Sometimes Never

Does your child imitate sounds or words? Always Sometimes Never

Does your child play appropriately? Always Sometimes Never

Does your child play with a variety of toys? Always Sometimes Never

Does your child take turns? Always Sometimes Never

Does your child tell stories? Always Sometimes Never

Does your child listen to others? Always Sometimes Never

Does your child comment appropriately regarding what people say? Always Sometimes Never

READING / SPELLING

Does a family member have a learning disability or dyslexia? Yes No

Does your child have difficulties learning the alphabet? Yes No

Does your child have difficulties pronouncing the letters in words? Yes No

Does your child have difficulties reading despite additional remediation or tutoring? Yes No

Does your child have difficulties spelling? Yes No

Is your child a slow reader? Yes No

Does your child have to re-read sentences to understand the meaning? Yes No

Does your child dislike or avoid reading? Yes No

Does your child enjoy going to school? Yes No

Does your child have difficulties in certain subjects? Yes No

BEHAVIOR

Does your child eat well? Yes No

What are his/her favorite snacks? ____

Does your child sleep well? Yes No

Does your child have difficulty concentrating? Yes No

Is discipline difficult at home? Yes No

What are your child's favorite

toys/games?____
____

____

Check the traits that describe your child:

_____Easily makes friends _____Withdrawn _____Temper tantrums

_____Stubborn _____Uncooperative _____Cooperative

_____Shy _____Happy _____Other___________________________

FAMILY HISTORY

Please list family members in the home:

1)____________________________________ mother/father/sibling/other

2)____________________________________ mother/father/sibling/other

3)____________________________________ mother/father/sibling/other

4)____________________________________ mother/father/sibling/other

5)____________________________________ mother/father/sibling/other

6)____________________________________ mother/father/sibling/other

Do other family members have communication, learning disabilities, fine, or gross motor difficulties?

Please List:
____

____

EDUCATION

Please list school/daycare and grade your child is in**.**
____

____

Sensorimotor History

Tactile Processing: Does the child:

	Y	N
• Object to being touched?	Y	N
• Dislike being cuddled?	Y	N
• Dislike the feeling of certain fabrics?	Y	N
• Dislike to have his/her socks/shoes on?	Y	N
• Dislike having his/her face washed?	Y	N
• Dislike having his/her hair washed/brushed?	Y	N
• Dislike having his/her teeth brushed?	Y	N
• Want tags cut out of his/her clothes?	Y	N
• Dislike playing in messy materials?	Y	N
• Underreact/ overreact to getting hurt?	Y	N

• ____

____

Auditory Processing: Does the Child:

	Y	N
• Cover his/her ears in reaction to loud sounds?	Y	N
• Seem under-responsive to noises?	Y	N
• Miss some sounds?	Y	N
• Like to make loud noises?	Y	N
• Become easily distracted by background noises?	Y	N
• Have a diagnosed hearing problem?	Y	N
• Have a diagnosed speech problem?	Y	N

• ____

____

Visual Processing: Does the Child:

	Y	N
• Have a diagnosed visual deficit?	Y	N
• Loose his/her place while reading/writing?	Y	N
• Display poor eye contact?	Y	N
• Appear sensitive to light?	Y	N
• Make reversals during reading/writing?	Y	N

• ____

____

Olfactory and Gustatory Processing: Does the Child:

	Y	N
• Smell non-food items?	Y	N
• Lick or mouth non-food items?	Y	N
• React negatively to smell?	Y	N
• Eat a limited variety of food?	Y	N
• Seem unaware of tastes or smells?	Y	N
• Gag or vomit in reaction to tastes/smells?	Y	N

• ____

Proprioceptive Processing: Does the Child:

- Love to be held tightly? Y N
- Push hard on people/objects? Y N
- Seek pressure on his/her body? Y N
- Head bang intentionally? Y N
- ____
  ____

Vestibular Processing: Does the Child:

- Always seem to be on the "go?" Y N
- Enjoy spinning activities, but never seems to get dizzy? Y N
- Avoid balance activities? Y N
- Become fearful if their feet leave the ground? Y N
- Appear to be clumsy? Y N
- ____
  ____

Regulatory concerns: Does the child:

- Have difficulty with bowel/bladder training? Y N
- Smear feces? Y N
- Have difficulty with sleeping patterns? Y N
- Have poor appetite control? Y N
- Have difficulty attending? Y N
- Display an unusually high/low energy level? Y N
- Have excessive emotional/behavioral outbursts? Y N
- ____
  ____

Muscle Tone: Does the child:

- Tire/ fatigue quickly? Y N
- Display poor muscle strength? Y N
- Prop his/her head up when writing/drawing? Y N
- Prefer to lie on his/her back rather than their stomach? Y N
- Prefer sedentary activities? Y N
- Display a weak grasp on writing or eating utensils? Y N
- Hold his/her mouth open unnecessarily? Y N
- ____
  ____

<u>Additional Comments:</u>

____

____

____

Address **14415 E State Road 70**
Bradenton, FL 34202

Get Google Maps on your phone
Text the word "GMAPS" to 466453

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