All of Me Therapy, LLC

Date: _____

CHILD/FAMILY HISTORY

Child's Name _____ Birthdate _____ Age _____ Sex ☐M ☐F Grade _____
Primary language(s) in the home _____ Child's primary language _____
Name and relationship of person completing questionnaire _____

REFERRAL INFORMATION

Referred by (family, physician, clinic, other professional etc.) _____
What are your main concerns regarding your child's communication skills?

_____
What do you hope to gain from this evaluation?

_____

RESPONSIBLE PARTY

Responsible party and relationship to child _____
Address _____
Cell Phone _____ Accept text messages? ☐Y ☐N Home Phone _____
Work Phone _____ Email _____
I give consent for All of Me Therapy, LLC to communicate with me and my therapy providers through non-secured electronic correspondence (email & texting). I acknowledge and agree that information sent via email is not considered secure. Therefore, I agree that All of Me Therapy, LLC has no liability to me for any loss, claim, or damages arising or in any way related to response(s) to any email or other electronic communication.
Parent/Guardian Signature: _____ Date: _____

FAMILY INFORMATION

Parent's marital status: ☐Married ☐Separated ☐Divorced ☐Single ☐Deceased ☐Other
Any other caregivers? _____
What are the child's favorite activities and/or games?

_____

DEVELOPMENTAL HISTORY

Prenatal

☐Premature labor ☐Medications other than prenatal vitamins ☐Diabetes ☐Preeclampsia
☐Bleeding/spotting ☐Premature rupture of membranes ☐Exposure to smoke ☐Exposure to drugs
☐Exposure to alcohol ☐Exposure to domestic violence
Comments: _____

Labor and Delivery

Gestational Age? _____ ☐Vaginal Delivery ☐C-Section Birth Weight? _____ Birth Length? _____
☐Regular Nursery ☐NICU Length of stay? _____ Reason for extended stay?
_____
Any complications during or after delivery?

_____

Infancy/Childhood

Any reactions to immunizations? _____
Breastfed ☐Y ☐N How long? _____ Thumb sucking or pacifier use? ☐Y ☐N How long? _____
Toilet trained? ☐Y ☐N Age? _____ Health concerns? ☐Y ☐N Explain _____

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Milestones

My child was (check all that apply): ◻alert ◻easily comforted ◻colicky ◻aware of light/sound ◻difficult to comfort ◻lethargic

My child's early motor development (walking, talking toileting, etc.) was: ◻early ◻average ◻late

Please indicate when each milestone was met:

Sat up unassisted _____ Crawled _____ First word _____

2-3 word phrases _____ Walked unassisted _____ Full sentences _____

Did the child babble and coo? _____ Was the child a quiet baby? _____

Health

Physician (name, address, phone number)

_____ Date of last visit? _____

How would you describe the child's current general health? _____

Is there a history of any of the following?

	Yes	No	Comments
Autism/PDD			
Ear Infections			
Serious Injuries			
Surgeries			
Hospitalizations			
Sensory Integration Issues			
Feeding Problems			

Is the child currently taking any medications? _____ For what? _____

Any allergies? _____ Is the child following a particular diet? _____

Visual Development

Date of last eye exam? _____ Results? _____

Does the child wear glasses? ◻Y ◻N Is the child sensitive to light? ◻Y ◻N Does the child squint? ◻Y ◻N

Any other concerns with the child's vision?

_____

Auditory Development

Date of last hearing screening? _____ Results? _____

Chronic of ear infections? _____ How many? _____ PE Tubes? _____ How long? _____

Does the child have a diagnosis of hearing loss? _____ Correction? _____

Speech and Language Development

Is the child talking yet? ◻Y ◻N

Describe the child's speech and language and any problems

_____

Does the child have difficulty pronouncing certain sounds? _____ If so, please list _____

Does the child mumble often? _____ Does the child seem inhibited by his/her speech difficulty? _____

What is the child's communication level? ◻Gestures ◻Words ◻Phrases ◻Sentences

Expressive Language

◻Y ◻N Does the child use 50+ words?

◻Y ◻N Does the child answer yes/no questions?

◻Y ◻N Does the child answer 'wh' questions?

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Motor Development

Hand Dominance: ☐R ☐L Age Established? _____

Does the child:

Muscle Tone

☐Y ☐N Have a grasp that is less mature than peers/

☐Y ☐N Seem weaker or stronger than normal? Explain: _____

☐Y ☐N Have any diagnosed muscle pathology? (e.g., spasticity, flaccidity, rigidity) Explain: _____

Coordination

☐Y ☐N Have difficulty manipulating small objects easily

☐Y ☐N Seem accident prone?

☐Y ☐N Eat in a sloppy manner?

☐Y ☐N Have difficulty dressing and/or fastening clothes? Explain: _____

☐Y ☐N Have a consistent hand dominance?

☐Y ☐N Have trouble riding a tricycle and/or bicycle?

☐Y ☐N Have trouble playing on playground equipment?

Social Interactions and Behavior

How would you describe the child's social interactions? ☐Typical for age ☐Quiet ☐Outgoing

Any other behavior or emotional concerns? _____

PREVIOUS EVALUATIONS AND TREATMENT

Is there a family history of speech, language, or learning disabilities? _____ If yes, please explain

_____

Has your child been diagnosed with Autism Spectrum Disorder? _____ Age at diagnosis? _____ Who diagnosed? _____

Has your child previously been diagnosed with any condition that would affect his/her speech, language, or auditory skills? (Down Syndrome, PDD, Cerebral Palsy, Hearing Impairment, etc.)

_____

Has the child been evaluated for speech, language, or auditory problems in the past? _____ When? _____

Results? _____

Has the child been evaluated by a physical or occupational therapist in the past? _____ When? _____

Results? _____

Has the child been evaluated by a psychologist or learning specialist in the past? _____ When? _____

Results? _____

Has the child been evaluated by a neurologist in the past? _____ When? _____

Results? _____

Has the child been evaluated by and ear-nose-throat physician? _____ When? _____

Results? _____

EDUCATIONAL HISTORY

Did the child attend preschool? ☐Y ☐N Ages? _____ Where? _____

Has the child ever repeated a grade? ☐Y ☐N Which grade? _____

Has the child ever participated in a special education evaluation? ☐Y ☐N When? _____

Has the school system implemented an IEP for the child? ☐Y ☐N Date: _____ School? _____

Please list:

Strengths	Weaknesses

Are there any significant behavior problems or concerns?

_____

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Please check all areas of concern

☐	Attention	☐	Focusing
☐	Following Directions	☐	Understanding what is being said
☐	Behavior	☐	Speech
☐	Language	☐	Tantrums
☐	Motor Skills	☐	Reading and Spelling
☐	Learning	☐	Social Skills
☐	Transitions and Flexibility	☐	Sleep Patterns
☐	Food Habits	☐	Other (describe)

Describe the child's interests and activities:

_____

Is there any additional information that would help us better understand the child?

_____

"Therapy with Heart"
8626 Wicker Ave., Suite C, St. John, IN 46373
Phone: 219/440-7930 Fax: 219/440-7931 Email: info@allofmetherapy.com www.allofmetherapy.com

All of Me Therapy, LLC

Clinic Policies and Financial Agreement

1. Sessions will begin and end at designated times. Speech therapy services are provided in 45-minute increments and occupational therapy services are provided in 60-minute increments. A parent or guardian must be on site 10 minutes prior to the end of the session. We do not have additional staff available to monitor children after their session is completed and we must remain fair to the following client and start the next session on time. If you leave and do not return to the clinic prior to the end of your child's session the following will apply: 1st time: Reminder of policy, 2nd time: $25 fee, 3rd time: You will no longer be able to leave the clinic during sessions or your child will be removed from the schedule. _____(initial)
2. Please make sure your child has a chance to use the restroom prior to beginning therapy. If your child wears diapers, please make sure the diaper is clean and dry prior to the beginning of the session. If you choose to leave the clinic for any reason you must leave changing supplies (diapers, wipes, and change of clothes), as we do not have these supplies on hand. If you do not leave changing supplies, we require you to remain in the clinic for the entire session in event of an accident. _____(initial)
3. Our clinic is a teaching facility, therefore, there may be times when sessions are observed, or conducted, by supervised student clinicians, SLP-A's or COTA's. _____(initial)
4. There may be times when you will not be scheduled with your usual therapist. Rest assured that all our therapists provide the same level of exceptional care. _____(initial)
5. A minimum 4-hour notice is required to cancel a session. **Cancellations with less than 4-hour notice will incur a $75 cancellation fee charged to your account. NO -SHOW sessions will incur a $150 fee charged to your account.** Make-up sessions must be scheduled and attended within 2-weeks of the cancelled session. Any cancellation fees will be removed after the makeup session is completed. Insurance will not be billed for cancelled or no-show sessions, and fees will be billed directly to the family. _____ (initial)
6. Cancellations of more than 3 sessions per quarter, without makeups attended, will result in your child being removed from the schedule immediately upon the 3rd cancellation. Quarters are January 1st - March 31st, April 1st – June 30th, July 1st – September 30th, and October 1st – December 31st. _____(initial)
7. Family understands they are ultimately responsible for all charges not covered by outside resources, such as insurance. _____(initial)
8. As a courtesy, we will file insurance claims on your behalf. Cash, copay, or co-insurance payments are due at the time of service. _____(initial)
9. Insurance plans that require a referral are the responsibility of the insured and referrals must be on file with our office before treatment can begin. Families assume financial responsibility for any treatment sessions that are not authorized for insurance coverage. _____(initial)
10. We ask that families review statements issued by their insurance companies, which reflect payments made to All of Me Therapy, LLC, to ensure accuracy and to stay up to date on benefit status.
11. Brief session notes will be kept each session. Progress notes will be completed every 6-months. A complete, formalized re-evaluation of progress will be conducted annually.
12. All session notes, evaluation, and re-evaluation reports can be accessed through your online client portal. There will be a $0.25/page charge ($20.00 max.) for paper copies of any log notes, evaluations, or re-evaluation reports.
13. Rates are as follows:
    a. Insurance or other outside resources: $200/individual session, $450/initial evaluation, $300/annual re-evaluation, services outside of direct therapy (such as school meetings, etc.) $100/hour. Insurance copays are due at the time of service.
    b. Cash payments: $105/45-minute speech session, $136.50/60-minute occupational therapy session, $315/initial evaluation, $250/annual reevaluation, services outside of direct therapy (such as school meetings, etc.) $100/hour. Cash payments are due, in full, at the time of service.
14. Invoices are emailed to clients through SQUARE and may be paid online.

I have read, understand, and agree to the clinic policies listed above. I understand that I am responsible for ensuring payment of services and understand that visits may be terminated, and documentation withheld until payment is received in full. I understand that visits may be terminated at any time by either party and I agree to comply with the policies stated above.

_____	_____	_____
Patient's name (print)	Parent/Guardian Signature	Date

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All of Me Therapy, LLC

TELEPRACTICE INFORMED CONSENT/DECLINE FORM

Due to the closure of our practice in March of 2020, because of COVID-19, we adapted our service delivery model to include teletherapy services to maintain continuity of services for our families. We have reopened and are resuming face-to-face services and plan to discontinue most regularly scheduled teletherapy by August 31, 2020. However, in the event of an emergency, extreme circumstances, or another government-mandated closure, we want to provide families with the option of teletherapy to maintain continuity of services. Please indicate your interest in receiving teletherapy if needed:

_____YES, we would like to utilize teletherapy if needed.

_____NO, we are not interested in teletherapy at any time.

Telepractice, the act of providing telehealth services, is defined as "the application of telecommunications technology to delivery of professional services at a distance by linking clinician to client, or clinician to clinician, for assessment, intervention, and/or consultation." This means that we can provide therapy services through digital meetings similar to the popular communication system "Skype." While we do not specifically utilize Skype for the provision of services, the method of delivery would be similar in nature. The therapist and the child would join a computer-based session at the designated therapy time and would work on the same materials as in the office. We term this "teletherapy."

I _____, the legal parent/guardian of _____(child's name) hereby consent to engage in teletherapy with All of Me Therapy, LLC. I understand that "teletherapy" includes treatment using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical information, both orally and visually.

I understand the following with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is confidential.

2. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of All of Me Therapy, LLC, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

3. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

4. Teletherapy has been determined as an appropriate service delivery model for this patient. Teletherapy will only be used if determined to be at least as effective as in-person treatment. If teletherapy is not deemed as effective, you will be notified and referred to in-person treatment. To participate in teletherapy, the patient must first participate in an in-person evaluation. For certain individuals, we ask that an adult facilitator be present in the room for assisting with technical difficulties or keeping a child on task. Teletherapy will only be used for the duration of the COVID-19 crisis.

5. I have read, understand, and agree to the information provided above.

_____	_____	_____
Patient's name (print)	Parent/Guardian Signature	Date

All of Me Therapy, LLC

Authorization to Bill Health Insurance/Assignment of Benefits

Primary Insurance Information

Insurance Company: _____ Phone: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy ID Number: _____ Group #: _____ Relationship to Patient: _____

Please Circle: ☐ HMO ☐ PPO ☐ Other _____

Secondary Insurance Information

Insurance Company: _____ Phone: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy ID Number: _____ Group #: _____ Relationship to Patient: _____

Please Circle: ☐ HMO ☐ PPO ☐ Other _____

I,_____ (print name) authorize All of Me Therapy, LLC, to bill _____ (name of insurance company) for services rendered by All of Me Therapy, LLC. I also agree to have any or payments made by said insurance company to be payable directly to:

All of Me Therapy, LLC
8626 Wicker Ave., Suite C
Saint John, IN 46373

By signing this document, I also agree to the following statements:

- I understand that I am responsible for understanding information about my health insurance policy and providing such information to All of Me Therapy, LLC, for correct billing. I am also responsible for notifying All of Me Therapy, LLC in the case of any changes in my health insurance status.
- I understand that All of Me Therapy, LLC will be providing services, and billing my health insurance for those services, at various times during the course of my care in this office.
- I understand that ultimately, I am responsible for payment of any and all charges relating to treatment and services that I have received at All of Me Therapy, LLC during my care.
- I understand that my insurance company and any related policy/plan may offer benefits for services provided at All of Me Therapy, LLC, but that such benefits do not necessarily guarantee payment for those services, charges for services not covered by my insurance policy/plan will be my responsibility.
- I understand that the policy of All of Me Therapy, LLC requires payment in full for all services rendered at the time of visit.

I understand the above information and agree that my health history and related information was completed correctly to the best of my knowledge, and I understand that it is my responsibility to alert All of Me Therapy, LLC of any change in my medical status or insurance coverage.

_____ _____

Signature Date

All of Me Therapy, LLC

Consent for Electronic Communication

I, _____, do hereby give consent for All of Me Therapy, LLC to communicate with me and my therapy providers through non-secured electronic correspondence (email & texting). I acknowledge and agree that information sent via email is not considered secure. Therefore, I agree that All of Me Therapy, LLC has no liability to me for any loss, claim, or damages arising or in any way related to response(s) to any email or other electronic communication.

Parent/Guardian Name: _____ Child's Name: _____
Child's Date of Birth: _____ E-mail Address: _____
Cell Phone Number: _____ Accept text messages? ☐ Yes ☐ No
Parent/Guardian Signature: _____ Date: _____

Photo Release

I, _____, Parent/Guardian of _____ hereby authorize and consent to the use of his/her visual image by All of Me Therapy, LLC for appropriate purposes, including but not limited to: still photography, videotape, electronic and print publications and websites. I give this consent with no claim for payment.

Signature _____ Date: _____

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of All of Me Therapy, LLC Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that All of Me Therapy, LLC reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____
Patient Name (print) Date

_____
Signature

_____
Relationship to Patient

PRINT

SUBMIT

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