SPEECH/LANGUAGE and OCCUPATIONAL THERAPY NEW CLIENT PACKET

Please complete and return the following forms, as well as any additional questionnaires we may have sent you, PRIOR TO YOUR FIRST APPOINTMENT.

Feel free to contact us at 340-719-7007 if you have any questions.

Mail forms to:  
JS Therapies, LLC  
PO Box 25223  
Christiansted, VI 00824

Fax to:  
(866) 411-7667

Email forms to:  
islandtherapysolutions@gmail.com

Required Forms

☐ Client Registration Form  
☐ Parent Questionnaire (2 pages)  
☐ Consent Form  
☐ Attendance/Cancellation Policy  
☐ Copy of health insurance card  
☐ Credit card authorization form
CLIENT REGISTRATION FORM

Date: ________________

Child’s Name: ___________________________ □ Male □ Female Date of Birth: _____________

Mother’s Name: ___________________________ Father’s Name: ___________________________

Primary Phone #: ___________________________ Alternate Phone #: ___________________________

Email: ___________________________ Primary language spoken in the home: ___________________________

Address: ___________________________

Emergency Contact: ___________________________ Emergency Contact Number: ___________________________

School/Daycare: ___________________________ Grade: _________ Phone #: ___________________________

MEDICAL INFORMATION

Primary Care Physician: ___________________________ Physician Phone: ___________________________

Referred by: ___________________________ Medical Conditions/Diagnosis: ___________________________

Current Concerns/Reason for Referral: ___________________________

Does your child currently see other Specialists? (Physicians, Counseling, etc.): Please list name & phone #.

____________________________________________________________________________________

INSURANCE INFORMATION

Does the child have insurance coverage? □ Yes □ No

Insured’s Name: ___________________________ Date of Birth: _____________

Primary Insurance Company: ___________________________ Employer: ___________________________

Policy # ___________________________ Group # ___________________________ Telephone: ___________________________

Secondary Insurance Company: ___________________________ Insured’s Name: ___________________________

Policy # ___________________________ Group # ___________________________ Telephone: ___________________________

I authorize our insurance benefits to be paid directly to JS Therapies, LLC. I also authorize JS Therapies, LLC or our insurance company to release any information required to process our claims. I agree to pay for all charges denied by my insurance carrier, including, but not limited to: non-covered services, deductibles, co-pays, cancellation fees, services exceeding maximum benefit limits, and for services for which a referral authorization was not properly obtained. I shall promptly notify JS Therapies, LLC of any changes in Insurance coverage.

* ______________________________________________________________________________________

Signature of parent/legal representative of child Date
ISLAND THERAPY PARENT QUESTIONNAIRE

Child’s Name: ___________________________________________ DOB: __________________

Parent/Guardian Name(s): ___________________________ Phone #: ________________

Email address: ____________________________________________________________

Birth History
Length of Pregnancy (weeks): ______ Birth Weight: ______ Type of delivery: __________
Complications at birth for baby: ________________________________________________
Treatment received by baby or mother: __________________________________________

Medical History
Please describe any important illnesses, injuries or surgeries, including colic, ear or chest
infections, etc. and the ages at which they occurred: _____________________________
___________________________________________________________________________
___________________________________________________________________________
Current medical diagnoses/conditions: (e.g., ADHD, Autism, asthma, LD): __________

Hearing Evaluation Results: _________________ Vision Evaluation Results: _________________

Current medications: _________________________________________________________

Allergies: ___________________________________________ Dietary restrictions: __________

Developmental History
At what age (in months) did your child: sit alone: ________ creep/crawl: ________ walk alone: ________

Did your child display strong preferences during the development of these skills, such as dislike of
being on their stomach, not crawling on hands & knees, scooting on their bottom, etc.?
___________________________________________________________________________

Have you noticed any differences compared to your other children or peers? Any concerns noted
by teachers, family, or daycare providers? __________________________________________
___________________________________________________________________________

Are there any eating concerns (picky eater, gagging, overstuffing, unable to feed self, drooling)?
___________________________________________________________________________

If your child is in school, does he/she receive any special education services?
□ Special Education _________ □ Speech _________ □ OT _______ □ PT _______

What other evaluations, therapy or special programs has your child had in the past and when?
___________________________________________________________________________

JS Therapies at Island Therapy Solutions – 5030 Anchor Way, Suite 9, Christiansted, VI 00820 – (340) 277-4995
Speech & Language Development

How well is your child understood (percent of the time) by:

Mom ______  Dad ______  Siblings ______ Unfamiliar adults ______

What is it like to have a conversation with your child?
___________________________________________________________________________

At what age did your child speak first word? ___________ Speak in sentences? ___________

Which sounds (if any) are incorrect?
______________________________________________________________________________

How many words can your child say? (List if fewer than fifteen) _________________________

Does your child have any difficulty understanding you? Please describe. _________________
______________________________________________________________________________

Do you have any difficulty understanding your child? Please describe. _________________
______________________________________________________________________________

Concerns

Please describe your concerns about your child, citing specific areas (motor weaknesses, eating, behaviors, academic difficulty, frustrations, self-help skills, peer relations, etc.):__
______________________________________________________________________________

What would you like us to help you and your child with?______________________________
______________________________________________________________________________

What are your goals for your child? ________________________________________________
______________________________________________________________________________

Additional Comments
CONSENT FORM
Child’s Name: DOB:

CONSENT FOR CARE AND TREATMENT: As the child’s parent/legal guardian, I hereby grant permission for the therapists at JS Therapies, LLC to provide routine therapeutic care to my child, including evaluations, therapeutic/educational activities, & other procedures and/or treatments prescribed by my child’s therapist as is necessary in their judgment.

* __________ Initials

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: I acknowledge that JS Therapies, LLC will use & disclose my personal health information for treatment, payment, & other healthcare operations and as otherwise permitted by law. I understand that I may request a copy of the Notice of Privacy Practices to provide further detailed information about how protected medical information about my child is used or disclosed.

* __________ Initials

RELEASE OF INFORMATION: I also allow the release of my child’s medical information to the following physicians, professionals, family members, or teachers:

____ school staff: __________ doctor: ________________ other therapists: __________________________

___ other: __________________________

This authorization is valid for the duration of my child’s treatment from the date signed below. I understand that I may revoke this authorization at any time, but will not hold JS Therapies, LLC responsible for already releasing information in good faith.

* __________ Initials

COMMUNICATION:
I authorize my child’s therapists to communicate with myself and the above-named individuals, regarding treatment recommendations and scheduling for my child, via:

☐ Text message ☐ Email ☐ I do not authorize communication via text or email.

* __________ Initials

PHOTOGRAPH RELEASE: I hereby authorize JS Therapies, LLC to photograph and/or videotape my child for the purposes of treatment, education, and professional reasons.

☐ I consent to my child being photographed and/or videotaped.

☐ I do not consent to my child being photographed and/or videotaped.

* __________

Signature of parent/legal representative of child Date
ATTENDANCE/CANCELLATION POLICY

Child’s Name: ___________________________ DOB: ___________________________

It is the intention of our therapists to be flexible in meeting client and family needs. We have established the following cancellation policy that will hopefully be both flexible and reasonable, as we work together to provide services to your child. Our policy is based on the need to avoid unfilled appointments. This is especially important due to the number of families waiting to receive services. Therefore, our policy is as follows:

• If you must cancel an appointment, please do so by giving at least 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. It is our policy that any cancellation with less than 24 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 scheduled therapy appointment.

• If your child is ill, please contact your therapist as soon as possible and leave a message to inform of cancellation so we can allow the opportunity for another child to utilize your appointment time. Understanding that emergencies do occur, it is our policy that cancellation due to illness with less than 3 hours’ notice will result in a charge of $50.00.

• If you miss your appointment and do not give notice, you will be charged the rate of $75.00. These charges are not reimbursable by your insurance company and must be paid at the time of your next scheduled therapy appointment.

• Three “no-show” cancellations, missing more than 50% of the scheduled treatment sessions, or habitual cancellations will result in the loss of a reserved treatment time slot and/or your child being discharged from therapy.

• 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.

Please feel free to contact us if you have any questions about this policy. We remain available to work with you and your child in making the best possible use of this important service.

* __________________________
Signature of parent/legal representative of child

________________________
Date

JS Therapies at Island Therapy Solutions – 5030 Anchor Way, Suite 9, Christiansted, VI 00820 – (340) 277-4995
Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

<table>
<thead>
<tr>
<th>Credit Card Information</th>
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</thead>
<tbody>
<tr>
<td>Card Type: □ MasterCard □ VISA</td>
</tr>
<tr>
<td>Cardholder Name (as shown on card): ____________________________</td>
</tr>
<tr>
<td>Card Number: ____________________________ Security Code: ________</td>
</tr>
<tr>
<td>Expiration Date (mm/yy): ____________________________</td>
</tr>
<tr>
<td>Cardholder ZIP Code (from credit card billing address): ____________________________</td>
</tr>
<tr>
<td>Email address: ____________________________</td>
</tr>
</tbody>
</table>

I, ____________, authorize Island Therapy Solutions/JS Therapies to charge my credit card for necessary co-pays for therapy services provided outside of the office setting for ____________________________ (child’s name). I understand that my information will be saved to file for future transactions on my account.

_________________________________________  Date

NOTE:
Credit card on file will be charged monthly for co-pay balance for services rendered during the previous month. A receipt will be emailed to the email address on file.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

First, we can and, as necessary, will use your medical information to treat you, operate JS Therapies, LLC and obtain payment from you or a third party. For example, if necessary we will send your health information to other healthcare providers to assist in your treatment. We will also share that information here at Island Therapy Solutions, LLC to assure ourselves that our employees are providing you with the finest treatment we can provide. We also provide necessary information to insurance companies & other entities involved in the payment & collection process.

Second, if required by law, we will allow others to have access to your health information. For example, if a valid subpoena is served upon us for your health information, we will provide it if we have your written authorization to do so. If you do not give us authorization but we are ordered to provide the information by a judge, we will do so. There are a number of other situations in which we will release your health information without your permission because we are required to do so by law; if you would like a list of those situations, please ask and we will provide it to you.

Third, we will not otherwise disclose your health information without receiving a written authorization from you to do so. You may revoke that authorization under some circumstances.

Fourth, we will phone you, and leave a message on an answering machine if appropriate, to remind you of appointments.

Fifth, you have certain rights with respect to your medical information. They are set forth below:
- a) you may request that we restrict the use of medical information in certain ways although we are required to abide by those restrictions in every instance;
- b) you may receive confidential communications about your health information;
- c) you may obtain copies of your health information or review it in person;
- d) you may request an amendment to your health information under certain circumstances;
- e) you may request an accounting of the disclosures we have made of your health information;
- f) you may obtain a written copy of this Notice by requesting one;
- g) you may ask us to send you health information other than by mail and to an address different than the one at which you normally receive mail; we will honor any such reasonable request.

Sixth, we are required by law:
- a) to protect your health information and to notify you of your rights;
- b) to follow the terms of this Notice in protecting your health information; and,
- c) to give you a notice in the event we change the terms of this Notice; we will post a copy of any revised Notice where this Notice is displayed and, if you are an active patient at the time of the change, we will mail you an explanation of the change.

Seventh, if you believe we have violated your privacy rights with respect to your health information, you may complain to us by filing a complaint with the person whose name and address appears below. You may also complain to the Secretary of Health and Human Services of the United States. If you complain, we will not take any action to retaliate against you.

Eighth, if you have any questions or comments about this Notice or our privacy practices or, if you want to make a complaint, please notify:
Office Manager
JS Therapies, LLC
5030 Anchor Way Suite 9
Christiansted, VI 00820
(340) 719-7007

Below is a list of additional situations in which we may make some or all of your health information available to others without your written authorization:
1. Where a governmental public health agency can require that we provide such information (e.g., a public health agency is collecting data on communicable diseases or mandated reporting of suspected child abuse);
2. If we have reason to believe that there is evidence of abuse neglect or domestic violence;
3. If by required to participate in judicial or administrative proceedings;
4. If we are required by law to participate in law enforcement activities, or in certain other instance where there is an emergency or similar situation;
5. In order to participate in certain types of research;
6. In order to avert a serious threat to health or safety of individual or the public.