SPEECH/LANGUAGE and OCCUPATIONAL THERAPY NEW CLIENT INTAKE PACKET
JS Therapies at Island Therapy Solutions

Speech-Language Pathologists (SLPs):
Allison Janusziewicz, MA, CCC-SLP - speech@islandtherapysolutions.com - 340-244-8140
Dora Deller, MS, CCC-SLP - ddeller@islandtherapysolutions.com - 340-227-7810

Occupational Therapists (OTs):
Julie Sommer, MSOT, OTR/L – jsommer@islandtherapysolutions.com - 340-277-4995
Chelcie Stanton, MS, OTR - cgoldman@islandtherapysolutions.com - 340-514-8253
Vanessa Swanson, MS, OTR/L - vswanson@islandtherapysolutions.com - 703-927-0518

OT/SLP Billing/Practice Manager:
John Schwaninger - jschwaninger@islandtherapysolutions.com - 618-975-3385

A lead therapist will complete an initial evaluation with your child to make recommendations for services, which may be provided in the office, at home, in school, or in daycare if schedules allow.

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

Contact John Schwaninger at (618) 975-3385 with 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
- ❑ Financial Agreement
- ❑ 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: _____

Mailing Address: _____

_____

Physical Address (If Different): _____

_____

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.): P*lease 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

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?
_____
_____

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.

- We understand that parents may run an errand during treatment time, but please ensure you are back in the waiting room **10 minutes prior** to the end of the session. Our therapists may want to speak with you regarding your child's progress, and our waiting room is not equipped or staffed to accommodate unsupervised children. Parents that are not back at time of pick-up will not be allowed to leave during future appointments.

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

FINANCIAL AGREEMENT **Child's Name:** **DOB:**

JS Therapies is committed to working with the families we serve to maximize service provision for all children and collect patient balances in a way that is efficient and convenient for families. Clients have the following options for paying co-pays, deductibles, and any other charges deemed to be patient responsibility.

Please choose ONE of the following options:

- ❑ **Credit card to be billed monthly for co-pays** accumulated during the month after insurance has paid the allowable amount of each session, or for self-pay amounts charged to client.

  * CC authorization form must be on file with JS Therapies. If card is declined more than 2 times and client does not respond within 1 week to pay balance due, a charge of $25 per week will accrue until balance is paid.

  * Credit card option is mandatory for any family whose child is seen for services at school, home, or daycare.

- ❑ **Pay At Session**. Client is responsible for paying co-payment amount at the front desk at the time of service for each session.

  * Clients whose children receive services at home/school/daycare must have CC on file.

  * After two late cancellations/no-shows, clients must have credit card authorization on file.

Please feel free to contact our billing manager if you have any questions about this policy, or if you are experiencing financial hardship and would like to discuss an alternative payment arrangement.

John Schwaninger: jschwaninger@islandtherapysolutions.com or 618-975-3385.

Thank you!

*

Signature of parent/legal representative of child **Date**

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.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA
Cardholder Name (as shown on card): _____
Card Number: _____ Security Code: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____ _____ Email address: _____

I, _____, authorize Island Therapy Solutions/JS Therapies to charge my credit card for necessary co-pays and deductible amounts for therapy services for _____ (child's name). I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature **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 Unites 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.