THANK YOU FOR CHOOSING ISLAND THERAPY SOLUTIONS!

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 Julie Sommer at (340) 277-4995 if you have any questions.

Mail forms to:

Island Therapy Solutions, 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

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.): 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 Island Therapy Solutions, LLC. I also authorize Island Therapy Solutions, 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 Island Therapy Solutions, 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:_______ pull to stand:______
walk alone:_______ first words: _______

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?
____
____

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 Island Therapy Solutions, 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 Island Therapy Solutions, 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:

____________________________ ____________________________ ____________________________

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 Island Therapy Solutions, LLC responsible for already releasing information in good faith.

∗ ________Initials

CONSENT FOR PARENT OBSERVATION: I understand that at times there will be other children in the same treatment area as my child, and their parents may be present to observe their own child's therapy.

☐ I consent to the presence of other parents in the same treatment area with my child.
☐ I do not consent to have other parents in the same treatment area as my child.

PHOTOGRAPH RELEASE: I hereby authorize Island Therapy Solutions, 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 our office 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

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 Island Therapy Solutions, 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
Island Therapy Solutions, LLC
5030 Anchor Way Suite 7
Christiansted, VI 00824
(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.