Connect the Dots
PEDIATRIC THERAPY

84 CENTENNIAL LOOP EUGENE, OR 97401

REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle:

Is this the legal name? ❑ Yes ❑ No	If not, what is your legal name?	Nickname:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Parent/Guardian Names:	Email:
	Home phone no.: ( )
Street address:	Cell Phone nos: ( ) ( )

P.O. box:	City:	State:	ZIP Code:

Who can we thank for your referral?

❑ Dr. ❑ Family ❑ Friend ❑ Other

Other family members seen here:

PAYMENT INFORMATION

Person Responsible for Payment:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

(Please give your insurance card to the receptionist.)

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary Insurance Company Name:	Policy no.:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Co-payment: $	Co-insurance: %

Patient's relationship to subscriber: ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Connect the Dots or insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***

PAYMENT POLICY

This is to notify you of Connect The Dots Pediatric Therapy, Inc. office policy for payment and collection of payment. Please read and if you have questions please discuss with our office manager or your therapist.

Parents/guardians are responsible for all charges resulting from treatment provided by Connect The Dots Pediatric Therapy, Inc.

Cancellations and Missed appointments policy
A 24 hour notice is required for all cancellations. This policy is in place out of respect for our therapists and our clients. Cancellations with less than a 24 hour notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that timeslot. Please note that missed appointments cannot be billed to insurance.

Primary/Secondary Insurance Billing
As a courtesy, we will bill most insurance carriers directly. It is your responsibility to provide correct information for billing your insurance. A copy of your current insurance card is required at your first visit. It is your responsibility to notify this clinic immediately if your insurance coverage changes. Patients are requested to determine benefits prior to their appointment. **Co-payments, co-insurance and deductible payments are due at the time of service**.

Outstanding accounts
When an account is 90 days overdue, we cannot continue to provide additional services, until a payment plan has been arranged with our billing office. Checks returned for non-sufficient funds (NSF), closed accounts or other problems are subject to a $30 service fee and any other charges incurred by Connect the Dots. Accounts subject to collection activity may be charged a 20% collection fee.

Non Covered Services
If I choose to obtain the services listed below and they are not covered by my insurance, I agree to be financially responsible for any and all related charges.

I have read and received a copy of the Payment Policy for Connect The Dots Pediatric Therapy, Inc. My signature below indicates that I understand this policy and that I agree to pay amounts due for services received. I have received a copy of the Privacy Practices.

Services provided for: ____
(*Patient's Name)*

Responsible Party's Signature: ____

Print Signature: ____

Date: ______________________

Confirmation of Receipt of Notice of Privacy Practices
Effective August 1, 2013

I, ___________________________________, legal representative of ____________________ (child's name), have received a copy of the notice of privacy practices from the office of Connect The Dots Pediatric Therapy. I understand if I would like to request a change from these practices, I will contact Connect The Dots Pediatric Therapy, Inc in writing at the above address.

Please initial the following statements that you are in agreement with:

______ I agree to allow Connect The Dots Pediatric Therapy staff to call my child's name in the waiting room.

______ I do not agree to allow Connect The Dots Pediatric Therapy staff to call my child's name in the waiting room.

______ I agree to allow Connect The Dots Pediatric Therapy staff to discuss my child's treatment session in the waiting room.

______ I do not agree to allow Connect The Dots Pediatric Therapy staff to discuss my child's treatment session in the waiting room. I will enter my child's treatment room 5 minutes before the end of the session in order to obtain a progress report and homework.

______ I agree to allow Connect The Dots Pediatric Therapy staff to send email reminders to the email address I have provided.

______ I agree to allow Connect The Dots Pediatric Therapy staff to text appointment reminders to the cell phone I have provided.

Child's Name: ____

Parent's Signature: ____

Print Name: ____

Date: _______________________

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Childs name: ____ DOB: ______________

Physician, office or person:

Address:

Phone: Fax#:

I authorize exchange of information between *Connect The Dots Pediatric Therapy* and the party or parties listed above. This may include therapy reports, EI records, school reports, medical records, e-mail, and telephone contact.

A photocopy of this document shall be considered to be as valid as the original. This authorization for release of information shall remain in effect until revoked and may be revoked by myself at any time by giving a written notice to *Connect The Dots Pediatric Therapy.*

I understand that the information obtained will be treated in a confidential manner and will not be given to a third party without my permission unless required by law.

Unless otherwise revoked, this authorization will expire on the following date/event/condition: __________________________________. If I fail to specify an expiration date/event/condition, this authorization will expire two years from the date signed.

_____________________________________ ______________________________
Please Print Parent/Guardian name Relationship to Child

_____________________________________ ______________________________
Parent/guardian signature Date

Achieving success takes effort! By signing this contract you are agreeing that you and your child will follow the treatment plan provided by your therapist. This includes being present in all sessions and participating in your individually designed home exercise program (HEP). Being present in the session means that when you are asked to join the play you will willingly do so and will follow the therapist's instructions. If you have other children we recommend that you make arrangements for their childcare so you will be able to be actively involved with the child who is receiving service at CTD. If you are unable to make other childcare arrangements, and your other children cannot sit quietly in the session, you will be asked to sit in the waiting room. Your therapist will bring you back to discuss any new additions to the HEP towards the end of the session.

We are so excited to be a part of your and your child's development! Your Plan of Care will include a set number of visits to promote skill development, educate you on how to best help your child, and develop a HEP with you. You will be advised at the end of each session of the progress your child is making. Should your child reach a point in therapy where their progress plateaus* or desired therapeutic outcomes are not achieved resulting from a breach of this agreement; your child will be removed from the schedule.

The therapist is responsible for determining if Connect The Dots is the correct placement for your child's needs. Please understand this determination may not occur in the first session, and may evolve as the therapist learns more about your child.

As the parent/guardian of ____, I agree to follow the following rules:

- I will be at All sessions and if I am not available I will have another caregiver present at the session.
- I understand that sitting in the session provides the best outcome for the HEP.
- There may be times that my full attendance in the session is not required, based on the specific goals of the plan of care. This will be addressed and managed on a case by case tx session.
- If my child is acting out or not cooperating I will help manage my child's behavior.
- I understand other parents and clients may be in the room and I will share space.
- I will ask questions or gain clarification if I do not understand something.
- I will be responsible for making sure my child participates in the HEP and bring my CTD tool kit to each session.
- I will follow school rules regarding illness or infection, and provide as much possible notice if I need to cancel.
- If I no show for scheduled appointments two times I will be removed from the schedule. My child may also be moved to a flexible schedule if I cancel frequently. Missed appointments are my responsibility to reschedule. I understand availability may be limited.
- Connect the Dots uses a team approach to therapy and my child may see several therapists over the course of treatment. I understand I may not be notified prior to a change in therapist. I will embrace the change as a chance for my child to practice how real life really works. This will give my child the opportunity to experience adjusting to change in a setting that is equipped to deal with helping children navigate transitions.
- I will be open and honest with my therapist about my child's behaviors, needs, medications skills and family dynamics.

I agree ____Date _______________________

*A developmental plateau can be an indicator that it is time for your child to practice and integrate the skills they have developed in therapy at home, This should be viewed as a celebration and achievement! Before we reach the point of taking a practice and integration "break", you and your therapist will have discussed and developed a plan for continued growth within the home.

Connect The Dots Intake Questionnaire

Please complete this questionnaire to the best of your knowledge. The more information you can provide the better that we can serve your child

Child's Name:_________________________________ **Date of Birth:** _______**Today's Date:** ______

Form Completed By: ______________________________ **Relationship**: _______________________

Pediatrician:______________________________ **Primary Diagnosis(if any)** :____________________

How did you hear about us? Reason for referral:

____

____

Please list specialists that your child sees: ____

____

Immunizations up to date? **Y / N** Explain____

Birth/Pregnancy History

Any problems with the pregnancy? **Y / N** ____

During Pregnancy, did mother: Use tobacco **Y / N**

Use Drugs or Medications **Y / N**

Drink Alcohol **Y / N**

Explain: ____

Was you child born full term? **Y / N** Number of weeks gestation: _________

Any problems at birth? **Y / N** Explain:____

____

NICU Stay? **Y / N** for how long? ________ On a ventilator? **Y / N** for how long? _______________

Feeding Difficulties? **Y / N** Explain: ____

____

Past History

Does your child have or has your child ever had:

Seizures **Y / N** Explain ____

Vision problems **Y / N** Explain ____

Hearing problems **Y / N** Explain____

Reflux **Y / N** Explain ____

Headaches **Y / N** Explain____

Hypertension **Y / N** Explain____

Cardiac Problems **Y / N** Explain____

Breathing Problems **Y / N** Explain____

84 Centennial Loop | Eugene, OR 97401 | P: (541) 255-2681 F: (541) 255-2682

Connect The Dots Intake Questionnaire

Please complete this questionnaire to the best of your knowledge. The more information you can provide the better that we can serve your child

Diabetes **Y / N** Explain____
Chronic Constipation **Y / N** Explain____
Broken Bones **Y / N** Explain ____

Bleeding Disorders **Y / N** Explain____
Malnutrition **Y / N** Explain____
History of Family Violence **Y / N** Explain_______________________________________
History of abuse **Y / N** Explain____

Any other serious illness or medical conditions: ________________________________
____

Allergies (and Reactions): ____
Surgeries (and Dates):____
Medications/Dosage:____

Has your child Received Therapy Services Before? **Y** / **N** Explain_____________________
____
*If **Yes**, please bring the evaluation/notes to your appointment*

Educational Information
School/Educational program or daycare currently attending_____________Grade level______
IEP or Early intervention Services received **Y** / **N**
If **Yes** what are the services for? ______________________________________
____

Does your child's teacher or daycare provider have concerns about your child's development?____
____

Does your child struggle with the following:
Feeding **Y / N** Explain____
Self Care **Y / N** Explain____
Fine Motor Skills **Y / N** Explain______________________________________
Mobility **Y / N** Explain____
Gross Motor Skills **Y / N** Explain_____________________________________
Sensory Processing **Y** / **N** Please Circle All that Apply:
Auditory Sensitivity **Tactile Sensitivity** **Movement Seeker** **Movement Avoider** **Emotionally Reactive**
Explain____

84 Centennial Loop | Eugene, OR 97401 | P: (541) 255-2681 F: (541) 255-2682

Connect The Dots Intake Questionnaire

Please complete this questionnaire to the best of your knowledge. The more information you can provide the better that we can serve your child

Communication **Y / N** (if yes, complete questions on next page)

(Communication) Does your child do any of the following:

- ❏ Understands what you are saying
- ❏ Follows simple directions (“shut the door” or “get your shoes”)
- ❏ Answers questions correctly (who/what/where/when/why questions)
- ❏ Uses speech to communicate (circle: 1-2 words / 3-4 words / Complete Sentences)
- ❏ Uses gestures to communicate
- ❏ Takes turns in play and conversation

How much of your child’s speech do you and others understand? ___________________________

____

Please describe your child’s strengths ____

____

What do you want us to know about your child that you are not comfortable talking about in front of your child during the evaluation?

____

____

84 Centennial Loop | Eugene, OR 97401 | P: (541) 255-2681 F: (541) 255-2682