4602 Cumberland Road
Fayetteville, NC 28306
Phone (910) 423-5622
Fax (910) 423-5538

Parent Questionnaire

Date_____

Patient's Name_____

Client's DOB_____

Client's SSN_____

Parent/Guardian_____ CSC Provider: _____

Street Address_____

Home Phone_____Work Phone_____Cell_____

Email address_____

Primary Insurance Provider_____Policy Holder_____

Policy Number_____Sponsor'sSSN:_____

Secondary Insurance_____Policy Number _____

Primary Doctor's Name/Clinic:_____

Primary Doctor's Address_____

_____

Primary Doctor's Phone No._____

What are your doctor's or child's teacher's concerns regarding the child's development?_____

What are YOUR concerns regarding the child's development?_____

How does the child communicate his/her wants and needs?

- ❑ Cries
- ❑ Points
- ❑ Uses short sentences
- ❑ Uses long sentences
- ❑ Uses one word at a time
- ❑ Makes sounds

Does the child attend daycare, school or preschool? If so, where?
- ❑ No
- ❑ Yes, _____

_____

How does the child play with other children their age? _____

Describe any difficulties with the pregnancy, labor or delivery. _____

_____

_____

Describe any difficulties after birth. _____

_____

Has the child been hospitalized? _____

Does the child have any allergies?
- ❑ None
- ❑ A Few _____
- ❑ Many _____

Has the child had any seizures? _____

What medication is the child on? _____

Do any medical specialists follow the child? _____

What were the results of the child's last hearing evaluation?
- ❑ Normal
- ❑ Concerns _____

What were the results of the child's last vision examination?
- ❑ Normal
- ❑ Concerns _____

How many ear infections has your child had?
- ❑ None
- ❑ Few _____
- ❑ Many _____

What languages are the child exposed to? _____

Did your child learn to walk between 11-18 months and talk between 18 months-two years old? _____

_____

_____

Describe your child's eating habits and sleeping patterns. _____

_____

Is your child toilet-trained? _____

If so, at what age? _____

_____

Describe your child's coordination compared with other children his/her age. _____

Have there been any significant traumas/moves or changes that may have affected your child? _____

_____

_____

_____

Has your child received any special services prior to being seen by Therapy Playground? _____

_____

_____

By signing below I, parent/guardian of _____ give permission to Therapy Playground to evaluate and provide treatment as needed.

_____ _____

Parent Signature Date

Therapy Playground, Inc.
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Child's Name	Date of Birth
Child's Medical Record #	Child's SS# (Optional)
I,	
(Parent/Legal Guardian or Personal Representative) Hereby authorize: Therapy Playground Inc.	
(Name of Provider/Agency/Individual) To disclose and exchange specific health information from the records (written and electronic) of the above named child to/from: (Recipient(s) Name/Address/Phone/Fax	
Phone: Fax: (Optional)	
For the following purpose(s): treatment and planning purposes	
Specific information to be disclosed/exchanged (check all that apply):	
o Birth Records/History o Health and Medical Records o Laboratory Results o Admissions/Discharge Summaries o Ophthalmological Evaluations o Audiological Evaluations o Social History o Developmental History o Physical Therapy Evaluations o Occupational Therapy Evaluations o Speech and Language Evaluations o Developmental Assessments o Behavior Plan o ABA Treatment Plan	o Nutritional Assessments o Educational Evaluations o Psychological Evaluations o Medical Evaluations o Multidisciplinary Evaluations o Individualized Family Service Plans [IFSP] o Habilitation/Treatment Plans o Progress Reports/Progress Notes o Intermediate Assessments o Equipment o Other [specify] All records needed for treatment and planning RESTRICTIONS See Specific Request

I understand that this authorization will expire on the following date, event, or condition: one year from signature

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time by signing the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requestor of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, this disclosure may include that information. I understand that I may request that the disclosure of this information be restricted. I also understand that I may refuse to sign this authorization. I also understand that the Infant-Toddler Program cannot deny or refuse to provide treatment or eligibility of benefits if I refuse to sign this authorization. (Note, however, if treatment is research related, treatment may be denied if authorization is not given.)

I further understand that I will receive a copy of this signed authorization.

Signature of Client	Date	Witness and Date (if required)
Signature of Parent, Legal Guardian, Personal Representative	Date	Relationship/Authority

NOTE: This Authorization was revoked on: _____ _____

Date Signature of Staff

AUTHORIZATON TO DISCLOSE HEALTH INFORMATION

REVOCATION SECTION

I do hereby request that this authorization to exchange/disclose health information of:			
			Name of Child
Signed by:		On	
	(Enter Name of Person Who Signed Authorization)		*(Enter Date of Signature)*
Be rescinded, effective			
	Date		
I understand that any action taken on this authorization prior to the rescinded date is legal and binding.			

Signature of Client		*Date*		*Witness and Date (if Required)*
Signature of Parent,Legal Guardian, Personal Representative		*Date*		*Relationship/Authority*

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Payment for Services Agreement

_____ (Responsible Party) enters into an agreement with Therapy Playground, Inc. as of __ _____(today's date) with the following provisions:

Services to be Provided: Therapy Playground, Inc. will provide therapy services for _____ (patient) in accordance with the orders provided by the patient's physician. It is understood that licensed therapists employed by Therapy Playground, Inc will complete the services provided. The responsibly party gives permission for the patient to receive therapy services provided by Therapy Playground, Inc.

Insurance Benefits: Therapy Playground, Inc. will verify the patient's benefits, file the claims for services provided with the insurance carrier, and notify the responsible party of their financial responsibility. The responsible party understands that the verification of benefits is not a guarantee of payment and that they are responsible for all charges not paid by the insurance company.

Assignment of Insurance Benefits: The responsible party authorizes any insurance carrier that provides insurance coverage for the patient, to make direct payments to Therapy Playground, Inc. for any speech pathology services rendered. The responsible party will accurately inform Therapy Playground, Inc. of the patient's insurance coverage and provide information regarding coverage changes within 5 working days of the change.

Release of Information for Reimbursement: The responsible party authorizes the release of information pertaining to the patient's diagnosis and course of treatment to Therapy Playground, Inc. by the patient's physician and any other therapy service providers involved in the patient's care. The responsibly party also authorizes the release of information to the patient's physician and any other agencies related to reimbursement issues.

The responsible party and Therapy Playground, Inc. have executed this agreement on this date and agree to comply with the policies outlined.

Signature of Responsible Party:_____Relationship:_____
Printed Name:_____Date:_____
Signature of TP Staff:_____Position:_____
Printed Name:_____Date:_____

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Therapy Services Agreement

Therapy Playground, Inc strives to provide quality treatment services for your child. Regular attendance is necessary to establish a positive treatment routine and to ensure progress is made toward your child's goals. We want your family to view your child's treatment appointment as a regularly scheduled event.

In fairness to children currently waiting for services, please be advised of our attendance policy that is listed below:

1st No Show – you will receive a call from your therapist and receive a No Show letter
2nd No Show – your child will be discharged from the practice completely

If you cancel your child's appointments often, your child's status will be reviewed to determine if we will be discharging them from services for lack of attendance.

If your child is discharged for attendance and you decide to reenroll your child at our agency, you will be charged a $25 fee to reopen your child's record. This fee covers our cost in retrieving your child's chart from storage and reprocessing the intake forms.

Thank you for allowing Therapy Playground, Inc to service the treatment needs of your child.

By signing below, I the parent/guardian of _____agree to the above stated therapy services agreement.

_____ _____

Parent/Guardian Signature Date

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Student Participation Agreement

Therapy Playground, Inc strives to provide quality treatment services for your child. Part of providing quality treatment is supervising students in direct delivery of speech-language, occupational and physical therapy services. Their participation during treatment sessions prepare them for the workplace.

We are currently affiliated with Fayetteville Technical Community College, North Carolina Central University, East Carolina University for practicum placements.

We would like your permission to allow the students direct supervised contact during your child's therapy sessions. All students will sign a confidentiality agreement indicating they will keep the information they encounter at Therapy Playground in the strictest of confidence.

In the event a licensed therapist is not available to supervise the treatment of your child, the student will still provide services that will not be billed to your insurance. Please feel free to ask any questions regarding this policy.

By signing below, the parent/guardian of _____ agrees to the above stated student participation agreement.

_____ _____

Parent/Guardian Signature Date

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Home Visit Parent Questionnaire

1. Please provide us with directions to your home from the nearest main road. What does your home look like?_____
_____
_____
_____.

2. Where should we park at your house? Which door should we use?_____
_____
_____
_____.

3. Who will be present for the treatment sessions?_____
_____.

4. Who are we allowed to discuss your child's progress with? _____
_____
_____.

5. What type of indoor or outdoor pets do you have?_____
_____
_____.

6. Do you have any weapons in your home?_____
_____.

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Speech-Language Pathology Assistant
Authorization to Treat

Due to caseload demands and staffing needs, Therapy Playground has made a decision to employ Speech-Language Pathology Assistants at this time. The SLPA will be directly supervised by our SLPs, with the SLP evaluating your child, establishing a treatment plan and then instructing the SLPA how to implement the treatment goals. Please read the attached informational handout regarding SLPAs. If you have any questions or concerns regarding your child's progress in treatment, you should contact the supervising SLP. We appreciate any feedback you may have about this process.

By signing below, the parent/guardian gives permission for their child to be treated by the SLPA under the supervision of the SLP.

Child's Name:_____

SLPA's Name:_____

SLP's Name:_____

Parent's Name:_____

Parent's Signature:_____

Date:_____

Speech-Language Pathology Assistants

A SLP is a specialist who works with individuals to improve their communication skills. An SLP may work with stuttering, voice, language and articulation disorders. An SLP may work in a school, hospital, nursing home, private practice, university or other health care setting.

North Carolina approved a program to train SLPAs in order to help SLPs do their jobs. Just as dentists have assistants, SLPs now have SLPAs. The SLPA does not have to be directly observed during every treatment session by the supervising SLP. The SLP may opt to occasionally sit in on a treatment session to observe progress and make changes to treatment plans when needed.

The SLPA registers with the NC Board of Examiners for Speech-Language Pathologists and Audiologists and is supervised by a NC licensed SLP. Registered SLPAs must have an Associate's Degree in Speech-Language Pathology Assisting. All SLPAs must pass a competency test.

SLPA's can:

- Perform screening tests
- Provide therapy following a written plan established by the SLP
- Help with scheduling patients, ordering supplies and filing information
- Help with research activities

SLPA's cannot:

- Give diagnostic tests or interpret results
- Write or change the treatment plan established by the SLP
- Counsel patients and families relative to speech-language disorders
- Provide treatment without having access to his/her supervisor
- Provide swallowing therapy