Therapeutic Beginnings
4510 Intelco Loop SE, Suite B
Lacey, WA 98503
Office: (360) 786-1753
Fax: (360) 786-1793

Therapeutic Beginnings on Capitol
108 22nd Ave SW, Suite 14
Olympia, WA 98501

PATIENT REGISTRATION FORM **Date: _____**

Patient Information

Patient Name :_____ Sex: M ( ) F ( )

Address :_____

City :_____ State:_____ Zip:_____

Home Phone :_____ Date of Birth:_____

Email address: _____

Physician:_____ Physician Phone:_____

Emergency Contact Person: _____ Phone:_____

Parent/Guardian Information

Parent/Guardian: _____

Resides with patient: Full time_____ Part time _____ Other _____

Cell phone: _____Work phone:_____

Employer:_____

Parent/Guardian: _____

Resides with patient: Full time _____Part time_____ Other _____

Cell Phone:_____ Work Phone:_____

Employer: _____

Insurance Information

Primary Insurance Company:_____

Subscriber:_____ Relationship to Patient:_____

ID#:_____ Group #:_____

Secondary Insurance Company:_____

Subscriber:_____ Relationship to Patient:_____

ID#:_____ Group #:_____

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Patient Information Form

Patient Name: _____ **Birth date**: _____

Please list people living with the patient currently:

Names	**Ages (of other children)**	**Relationship to the patient**

Please list any intervention your child now receives, along with names of personnel involved in your child's life. For example, any other therapists, counselors, school staff, etc. Please remember to also put these names on the Release of Information form so we will be able to discuss aspects of your child's evaluation and/or treatment plan:

_____

_____

_____

_____

_____

Current Concerns

Who requested this evaluation? _____

What are the current concerns? _____

_____

_____

_____

Does your child have a diagnosis? If yes,

explain_____

_____

When and where did you receive the diagnosis?

_____

_____

Family History

Are there any learning or developmental problems in the family history? ____Yes___No

If so, please describe: _____

_____

_____

Medical History

Any complications during pregnancy or delivery? _____ Yes _____ No

If so, describe: _____

_____

Was this birth a Cesarean? _____ If so, why? _____

Has your child had a hearing test?_____ If so, what was the outcome?_____

_____

Please describe your child's health since birth (illnesses, surgeries, etc.): _____

_____

_____

_____

Developmental History

Please list the age at which your child first demonstrated the following activities:

Held head up when on tummy: _____ Held a bottle: _____

Sat unsupported: _____ Ate table foods: _____

Crawled: _____ Walked alone: _____

Ran without falling: _____ Jumped up:_____

Caught a ball: _____ Drank from a cup with a lid: _____

Drank from an open cup: _____ Used a spoon without spilling: _____

What are some of your child's favorite activities?_____

_____

How many minutes will your child participate in a favorite activity?_____

What types of foods does your child eat? _____

_____

Does your child play with other children of similar age? _____ How often? _____

When was your child's first word?_____ Did he/she babble?_____

Is your child putting 2-3 words together?_____

Does he/she pronounce letter sounds correctly? _____ Please describe:_____

_____

Approximately how many words does your child say? _____ What are they? _____

_____

_____

Do others unfamiliar with your child understand what your child says? _____

Does your child understand what you say/request? _____

Does your child attend preschool or any developmental program? _____

If so, where and how often? _____

Has your child received any therapy evaluations or treatment in the past or currently? _____

If so, where and when? _____

_____

Describe movement activities your child enjoys: _____

_____

_____

Any difficulties with self care routines such as mealtime, bath time, bedtime or hair washing, brushing and cutting?

If so, please describe. _____

_____

_____

_____

What does your child dislike? _____

_____

Please provide any additional information you feel will be relevant to this evaluation: _____

_____

_____

_____

_____

_____

Please sign below for consent of treatment and to state that the above information provided is true and accurate.

Printed name: _____

Signature: _____

THANK YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE!

PLEASE REMEMBER TO BRING IT WITH YOU TO THE EVALUATION APPOINTMENT.

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CONSENT/RELEASE OF INFORMATION

I hereby give consent to Therapeutic Beginnings, LLC, Christopher Heistand, CCC- SLP, Inc. PS, and/or Renae Lewandowski, OTR/L, Inc. PS to use and disclose my photograph and protected health information for the purposes of treatment, payment, and health care operations.

The Notice of Privacy Practices of Therapeutic Beginnings, LLC, Christopher Heistand, CCC- SLP, Inc. PS, and Renae Lewandowski, OTR/L, Inc. PS provides more detailed information about how your protected health information may use and disclosed. You have the right to review the Notice of Privacy Practices before you sign this consent.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the address listed above. You may deliver your revocation by any means you choose (e.g. personally, by mail, or fax), but it will be effective only when Therapeutic Beginnings, LLC, Christopher Heistand, CCC- SLP, Inc. PS, and Renae Lewandowski, OTR/L, Inc. PS actually receives it. Your revocation will not be effective to the extent that Therapeutic Beginnings, LLC, Christopher Heistand, CCC- SLP, Inc. PS, and Renae Lewandowski, OTR/L, Inc. PS or others have acted in reliance upon this consent.

Consent is hereby granted for exchange of information between Therapeutic Beginnings, LLC, Christopher Heistand, CCC-SLP, Inc. PS, and Renae Lewandowski, OTR/L, Inc. PS and the professionals, agencies, persons listed below. Please write below names and addresses of anyone you would like information shared with regarding your child's treatment:

_____

_____

_____

_____

_____

_____ _____
Child's Name Date of Birth

_____ _____
Signature of Parent/Guardian/Responsible Party Date

Notice of Privacy Practices Acknowledgement

I have been provided an opportunity to receive and review the Notice of Privacy Practices.

_____ _____
Signature of Parent/Guardian/Responsible Party Date

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Financial & Office Policies Agreement

Thank you for choosing Therapeutic Beginnings for your child's therapy services. The following policies are provided so that you understand your responsibility regarding the services provided at Therapeutic Beginnings. Please read the Agreement, ask us any questions you may have, and sign in the space provided. A copy will be provided to you at your request.

1. Insurance. Insurance coverage is contingent upon your specific policy. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. We can assist you as best we can in determining your plan's coverage; however, most plans will not guarantee benefits until claims have been submitted and reviewed. Our financial relationship is with you, not with your insurance company, and you are ultimately responsible for your bill.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. We accept payment by cash, check or credit card.

3. Referrals and Pre-authorizations. Our office requires a referral with a diagnosis from your child's primary care provider (PCP) before being seen in our office. Certain health plans also require a pre-authorization or pre-certification to receive therapy services. Failure to obtain the pre-authorization may result in nonpayment from the insurance company. Alternative payment arrangements or rescheduling of your appointment may be necessary if pre-authorization is not obtained.

4. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or medically necessary by your insurance provider. You are responsible for payment in full once we are informed of the non-covered treatment.

5. Proof of insurance. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim.

6. Claims submission. As a courtesy we will submit your claims to your primary insurance. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. It is your responsibility to know any limitations of your insurance coverage. **We do not bill secondary insurance.**

7. Billing consent. Your signature below indicates you give consent for this office to bill your insurance carrier for services rendered. In addition, you authorize your insurance carrier to pay medical benefits for these services directly to this office.

8. Coverage changes. You agree to notify the office immediately upon change in your insurance coverage and provide valid insurance documentation prior to your appointment. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

9. Unpaid balance fee. An unpaid balance fee of $25 will be assessed on your account if a balance is carried over for more than two (2) months. Partial payments will not be accepted unless otherwise negotiated with our billing staff. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you will be discharged from this practice.

10. Missed appointments. Your appointment time is held exclusively for you; please provide no less than 24-hour notice if you will be unable to attend. Our no-show policy states that a $50 fee will be charged for failure to cancel or appear for a scheduled appointment and must be paid at the next scheduled appointment. More than two no shows may be cause for removal from our schedule. Please help us to serve you better by keeping your regularly scheduled appointment.

Thank you for understanding our financial and office policies. Please let us know if you have any questions or concerns.

I have read, understand, and agree to the information and conditions presented above.

Patient's name _____

Signature of parent/guardian _____

Print guardian name _____ Date _____

THERAPEUTIC BEGINNINGS ATTENDANCE POLICY

Session Length:

- Therapy sessions are scheduled for 30 (ST) or 60 (OT) minute sessions. Treatment sessions include set up & clean up of materials, discussion with parent or caregiver before and/or after the session, occasional written additions to home program, notes to document progress, as well as direct time spent with your child. Therefore, actual time spent with your child will be shorter than total minutes reserved and may vary slightly from one session to the next. Please ask your therapist if you have further questions about session length.

Scheduled Appointments:

- Please arrive for each appointment in time to check in and begin therapy at the scheduled time.
- If you will be more than 10 minutes late for your child's appointment, please contact the office.
- If you have difficulty getting your child to his or her appointment, please discuss this with the front desk so we can search for another time or we can offer flexible weekly call in scheduling.

Cancellations:

- **PLEASE PROVIDE NO LESS THAN 24 HOUR CANCELLATION NOTICE WHEN YOU WILL BE UNABLE TO ATTEND A SCHEDULED APPOINTMENT**. A message may be left 24 hours a day, 7 days a week. We reserve the right to assess a $25 fee, for same day cancellations.
- If you must cancel an appointment due to an illness or emergency, contact our front office **ASAP** before the scheduled appointment.
- Please verify with the front desk any appointments that will be cancelled due to a vacation. We request to receive this information at least 14 days prior to the dates which will be missed.
- In the event of inclement weather, contact our office the day of the event if you are unable to safely make it to the appointment. A fee will not be assessed.
- Frequently cancelled appointments, missing 50% of scheduled monthly appointments, will be basis for removal from your regularly scheduled treatment time.

No Shows:

- Failure to cancel or to appear during an appointment is considered a no show. A $50 fee will be assessed. Please contact our office immediately to discuss further appointments.
- If two consecutive no shows occur, we reserve the right to remove your child from their regularly scheduled appointment. If you are interested in resuming treatment in the future, please contact our office to discuss this possibility.
- The no show fee must be paid prior to the next scheduled appointment in order for treatment to resume. Kindly have your payment ready.
- If we are unable to reach you within 1 business day of a no-show appointment, your child is at risk of losing their weekly appointment.

We are unable to hold any time slot, for more than 2 consecutive weeks.

A note from the Therapists:
We expect you to make every effort to attend your scheduled appointments. In return, we will make every effort to be here regularly and on time for your child's appointment. When we establish a plan of care for your child, we base goals on the child consistently attending therapy sessions. The success of your child's treatment sessions depends on consistency and follow through with home program suggestions. If you have any questions or concerns regarding your child's therapy program, please discuss these with your child's therapist.

I have read the attendance policy and understand the attendance expectation for my child.

Patient's name _____

Signature of parent/guardian _____

Print guardian name _____ Date _____

Revised 12/23/2019