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Phone: (480)-508-5252
www.waytogrowaz.com

PATIENT INTAKE

Child's Name:_____ M / F Date of Birth: _____

Parent(s)/Guardian(s) 1) _____ 2) _____

Address:_____ City:_____ Zip code:_____

Home Phone:_____ Cell 1:_____ Cell 2:_____

Father's Employer:_____ Work Phone: _____

Mother's Employer:_____ Work Phone: _____

*Email Address:_____ *Main contact to send evaluation report and other correspondence

Emergency Contact (besides parents):_____ Phone:_____

Child Lives with (circle): Both parents Mom Dad other: _____

Siblings (name/age)_____

Child's School: _____ Grade:_____ 504/IEP (Circle): Y / N

Current Concerns and reason for referral: _____

_____

Goals for Treatment:_____

_____

BIRTH AND DEVELOPMENTAL HISTORY

Neonatal weight _____ length _____ **Delivery** (please circle): Vaginal Cesarean Emergency Y / N

Pre-Term/Gestational Weeks _____ Length of hospital stay _____

Complications (please circle all that apply): Gestational Diabetes Pre-Eclampsia Jaundice Seizures

Congenital Abnormalities Respiratory Distress Drug Withdrawal C-Pap or Intubation NICU Y / N _____

Went home on oxygen Y / N How long? _____

At what age did your child first.....

Roll Over:_____ Sit Alone:_____ Crawl:_____ Pull to Stand:_____ Stand:_____

Walk Alone:_____ Say first words:_____ Eat Baby food:_____ Eat solid foods:_____ Drink from cup:_____ Dress self:_____ Feed self:_____ Tie shoes:_____

Ride bike:_____ Dominant Hand: R / L or both

Is there anything else the therapist should know about your child? (e.g. behaviors, sensitivities, fears):

_____

_____

How did you hear about WTG? FB / Google Search / Yelp / Pediatrician / Friend / Other _____

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MEDICAL INTAKE

Name of Primary Physician: _____

Name of Practice: _____

Phone: _____ Fax:_____

Address:_____ Order/Script Provided: Y / N

Does your child see any other specialists? If yes, please list:_____

_____

Previous Hospitalizations:

Date	Type	Length

Patient Diagnosis:

Name of Diagnosis	Date of Diagnosed	Doctor of diagnosed

Current Medications (Name and indication):

Name	Dosage	Prescribing physician

Orthotics/Braces Used (Type, length of use): _____

Does your child have a history of (please circle): Seizures: Y / N Head Injury: Y / N Asthma: Y / N

Vision Loss/Correction: Y / N Hearing loss: Y / N Aides: Y / N If you answered yes, please explain: _____

_____

Are there any special precautions or limitations that pertain to therapy (e.g. Physician precautions) _____

_____

_____

Is there anything else the therapist should know about your child? (e.g. behaviors, sensitivities, fears):

_____

_____

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ALLERGIES: **Epi-Pen Needed: Y / N**

Food Allergy and Reaction (ie hives, breathing etc)	**Intolerance** and Reaction (ie hives, breathing etc)	**Environmental** and Reaction (ie hives, breathing etc)	**Medication** and Reaction (ie hives, breathing etc)

Patient History (circle all that apply)

Tics	Wear orthotics/prosthetics	Wears glasses/contacts
Asthma	Seizures (ask for Seizure Protocal)	Other:

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SPEECH/LANGUAGE BACKGROUND

Child's Name: _____ D.O.B.: _____

What is the child's primary language? _____

Are any other languages spoken in the home? Yes / No _____

Describe your current communication concerns: _____

_____

Has your child ever received speech-language and/or reading services before Yes / No

Location? _____

Explain_____

Do any immediate or extended family members have a history of the following? If yes, please explain familial relationship/diagnosis:

Language disorders? Yes/ No _____

Articulation disorders? Yes/ No _____

Learning disabilities? Yes/ No _____

Stuttering problems? Yes/ No _____

Current Communication Skills

Is your child able to:

Respond to his/her name?	Yes/	No	Engage in pretend/imaginary play?	Yes/	No
Point to objects when asked?	Yes/	No	Identify letters/recite the alphabet?	Yes/	No
Follow simple directions?	Yes/	No	Count consistently?	Yes/	No
Answer simple questions?	Yes/	No	Retell simple stories?	Yes/	No
Recognize familiar people?	Yes/	No	Do you have difficulty understanding		
Understand colors, shapes, and sizes?	Yes/	No	your child's speech?	Yes/	No

Please circle the phrases that describe how your child communicates (circle all that apply):

babbling	sign language	single words
pointing/gestures	2-word combinations	simple 3-4-word phrases
sentences with some errors	grammatically correct sentences	tells coherent and sequential stories

EDUCATIONAL INFORMATION

Does your child attend school? Yes / No Does your child have an IEP or 504? Yes / No _____

Name of School: _____ Grade: _____

Performing at grade level? Math: Yes / No Reading: Yes / No Writing/Spelling: Yes / No

Please explain your concerns in the area of academics:

_____

_____

_____

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Please explain any other concerns with your child's communication or learning that may help us better understand your child:

_____

_____

___

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FEEDING/SENSORY INFORMATION

Child's Name: _____ D.O.B:_____

Parent (s):_____ Phone: _____

Physician: _____ Phone: _____

Current Weight: _____ Height:_____

Approximate daily caloric intake: _____ Goal: _____

Medical and Developmental History:

Did your child breast or bottle feed? _____

Were there problems with feeding early on? Yes / No

If yes, Please explain:_____

_____

At what age did your child start eating solid foods? _____ mos./ yrs.

Has your child ever experienced a traumatic choking episode? Yes / No

If yes, when/where and what age? _____

_____

Has your child ever been treated for gastro-intestinal problems (GERD) or reflux? Yes / No

If so, please provide information: _____

_____

Ear Infections? Yes/no _____

Hospitalizations: Yes/ No If yes, please give dates and reasons: _____

_____

****Allergies associated with food**: _____

_____

Drinks from Bottle / Sippy Cup / regular cup ? _____

Can your child drink from a straw? Yes / No

Sensory Information:

Is your child sensitive to smells? If so list specific smells: _____

_____

Is your child sensitive to textures on hands, clothing, face, etc.? Yes / No

If yes, please describe _____

Does your child enjoy playing in wet, messy textures? Yes / No / Not Observed

Is your child sensitive to certain types of clothing: Yes / No _____

Does your child become upset with a wet or messy diaper? Yes / No

. . .

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Does your child enjoy bathing? Yes / No Oral Hygiene: Yes / No
Do you feel your child is sensitive to visual information or the appearance of what food looks like ? Yes / No
If so, explain _____

FEEDING EVALUATIONS ONLY

Feeding Information: Please be detailed and use space provided to give specific information.

Please list foods you DO NOT want your child to eat: _____

_____

Describes Meals in the home (times, location, atmosphere, routines or family dinner traditions):

_____

_____

_____

Behaviors observed during meals (e.g. gagging, vomiting, crying, whining, avoiding):-_____

_____

Does your child eat meals with family at the dinner table? If not, where and when does the child eat in comparison to family meals? _____

_____

Does your child eat with hands or use utensils? _____

Do they need physical assistance to feed themselves? _____

List of child's preferred foods: _____

_____

_____

List of foods that you would LIKE to see them eat: _____

_____

_____

Foods your child absolutely refuses to eat or even touch: _____

_____

Temperature of food is an issue? Yes/ No /Unknown?_____

Drinks/Liquids preferred: _____

Family Information:

Are any other family members extremely picky with foods, smells or textures? Yes / No

If yes, explain_____

_____

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Any other concerns related to feeding and eating?_____

_____

What are your goals for feeding therapy for your child? _____

Who referred you for a feeding Evaluation? _____

If a Pediatrician or Specialist, do you give us permission to contact them if we have questions?

Yes / No Contact Information/number: _____

For feeding evaluation please bring in a few "safe" preferred foods that your child enjoys eating as well as a non-preferred or "Challenge" food. A water bottle with a straw would benefit too.

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PHYSICAL THERAPY INFORMATION

Describe any current precautions or limitations: _____

_____

Primary mode of mobility: _____

Current Moto Skills)children 5 years and older

Jump in place?	Yes	No
Run?	Yes	No
Pedal a tricycle?	Yes	No
Ride a bike with training wheels?	Yes	No
Ride a bike without training wheels?	Yes	No
Jump rope?	Yes	No
Engage in pretend/imaginary play?	Yes	No
Identify letters/recite the alphabet?	Yes	No
Count consistently?	Yes	No
Retell simple stories?	Yes	No
Do you have difficulty understanding your child's speech?	Yes	No

Please circle the phrases that describe how your child communicates (circle all that apply):

Has balance issues	Falls frequently	Chronic toe walker
Complains of Pain Where: _____ How long: _____	has a head tilt R/L side	Has history of torticollis
	Plagiocephaly	delayed milestones

Please explain any other concerns with your child's communication or learning that may help us better understand your child:

_____

_____

_____

_____

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WTG Scheduling & Cancellation Policy

You are set up for Text and Email alerts that will remind you 24 hours before your regularly scheduled time. If you are not receiving them, it is your responsibility to notify reception before a missed/late appointment _____(Initials)

Missed Appointments

We understand life circumstances can get in the way of our best intentions, and cancelled appointments are bound to occur in your busy schedule. We will do our best to provide consistent services to provide the best opportunity for growth and progress towards your child's goals. We also ask that you take duel responsibility for holding scheduled appointments for your child. **Missed, or "Skipped" appointments not only negatively impact your child's progress, but it also takes valuable resources/time away from other children seeking services.** Our therapists are also prepared to see your child for their scheduled visit and do not receive regular reimbursement for a missed or skipped session. ***If you don't maintain at least 80% attendance rate, you will be put on a *flexible schedule.*** **No show or late cancellations will be billed at the private pay rate of $95.00 for hour sessions and $47.50 for half hour sessions.** _____ (initial)

**Flexible schedule – parent will call weekly and get their child on cancelled appointments. We don't recommend this as it can affect consistency of care.*

Late Arrivals

Just as missed or skipped appointments can negatively impact your child's progress, consistent tardiness, will also directly impact your child's progress towards their plan of care. Please note that session times will not be extended past the fifty-minute mark, unless prior arrangements have been made with the therapist ahead of time. If you are running late, please notify the front office as soon as possible so that your therapist is aware and can make changes in their plan for the session. **More than 25 minutes late, you will be charged at the private pay rate of $47.50 (this will not be paid by insurance). If you are consistently late for your sessions, we reserve the right to consider a flexible schedule or possible discontinuation of services.** _____ (initial)

Cancellation and Rescheduling

If you are needing to cancel or reschedule your child's appointment please make sure to do so with the front desk either in person, by phone (480-508-5252) or email (office@waytogrowaz.com) within 24hrs of your child's scheduled appointment. This is the **only** form of communication acceptable for making these changes. As a courtesy, please notify us as soon as possible if you are scheduling a vacation, or if your child is ill (Fever 100 or more, Flu virus, stomach flu, Strep throat, chicken pox, etc.) **We will require a minimum of two alternative times to reschedule your appointment prior to your next scheduled session.** We will do our best to try and accommodate the schedule changes.

Morning Appointments

If you are scheduled for an 8:00 or 9:00am appointment, we require a minimum of a **one-hour cancellation** notice. You may call and leave a message on our office number or email your therapist directly.

. . .

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****A minimum of a 4-hour notice is required for cancellation of services to avoid a "short notice" or "no show" fee of $95.00 for hour sessions and $47.50 for half hour sessions.**

This fee IS NOT billable to your insurance company. The payment will also be due before the next scheduled treatment session is provided. ***Please note, even if you re-schedule a make-up session for that week, the "No-Show" fee will still be applied and due on/before the following session. If you have 2 or more unexcused cancellations, skipped or "No Shows" without rescheduling, within a 4-week period, we reserve the right to discontinue services or place you on a flexible schedule.*** *Unexcused cancellations may include but are NOT limited to the following: scheduling conflicts with alternative appointments, vacations, difficult day/transitions. _____(initial)*

Sickness: Fever/Illness/Flu: present or within 24 hours of session will not be treated and short notice cancellation may still be applied if cancelled less than 4 hours prior to therapy session.

By signing below, **I understand and agree with all information as written above.**

_____ _____
Signature
Date

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Way to Grow Policies

Thank you for choosing Way to Grow, we will strive to meet your expectations and the needs of your child. It is imperative that you and your child are consistent with schedule and attendance so that we can meet your child's individual needs, provide the best care possible, and provide a permanent ongoing appointment time that accommodates your schedule and ours.

Our expectations parent/gaurdian/caregiver are:

-You will be responsible for contacting the front desk or office manager either in person, by calling (480-508-5252), or by email (office@waytogrowaz.com) for any schedule changes or concerns. *Please note that this is the **only** method of communication acceptable to make these changes.* Your therapist will be notified of these changes when they occur and is not in charge of scheduling changes.

-Please notify our office 24 hrs in advance for any cancellation or schedule changes; **a late cancellation fee of *$95.00 will be applied accordingly for "short notice" cancelations (4 hours or less prior to appointment time) or "no shows" (not arriving for a scheduled appointment)**. Early morning appointments (8:00 and 9:00am) require a minimum of 1-hour notice. **Half hour sessions will be charged $47.50 for short notice cancellations and no-show appointments.* _____(initials)

Please leave a voicemail at your earliest knowledge. Our voicemail is time stamped and checked before our office opens and we will be able to document and notify the treating therapist of cancellation appropriately.

-Be consistent with your child's sessions according to their therapist's recommendations in their plan of care. Interruption and missed appointments will not only affect your child's progress but can result in not receiving full benefits provided through our therapy services. ***Must attend at least 80% for each discipline (OT, feeding, PT, and ST) otherwise you may be switched to a flexible schedule.***
_____(Initials)

- ***You are set up for Text and Email alerts that will remind you 24 hours before your regularly scheduled time. If you are not receiving them, it is your responsibility to notify reception before a missed/late appointment _____(Initials)***

-Your child's sessions will run **50 mins for hour appointments and 25 mins for half hour appointments**. It is important that your child be picked up by the end of their appointment time, this will ensure that all patients receive their scheduled therapy time with their therapist. ***If you are more than 10 minutes late you will be charged a late pick up fee of $25**. _____(initial).

Late drop off notice - If you arrived 10 minutes late you will be charged $31.67, 25 minutes late you will be charged $47.50 and anything over 25 minutes will be charged a private pay rate of $95.00. Insurance will not pay this fee and it is unethical for us to bill insurance for time the therapist has prepared for and waiting on patient to arrive. If you are late THE SESSION WILL STILL END AT THE NORMAL SCHEDULED TIME as your therapist has other appointments after yours. _____(initial).

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-Please consider your therapist's privacy as well and refrain from emailing, texting or calling them on their personal cell phones. This includes Facebook, Messenger, other social media platforms, and personal emails. All communication is safely protected/encrypted through our business email addresses, and we prefer you use that as the supplemental form of communication, outside of directly communicating with them at time of service.

If any of this information changes (ie. medications, frequency, etc.) it is the parent/guardian's responsibility to notify Way to Grow LLC.

Way to Grow staff does not administer medications.

Parents/Guardians are asked to remain on site if your child is younger than 3 years old and/or has medical needs that may require medications as well as.

-Be courteous of others in our lobby and please refrain from talking on cell phones, eating food, climbing/jumping on/off furniture, and allowing young children to use the restroom unattended.

_____(initial)

By signing this I understand the scheduling policies and what I can expect from Way to Grow.

_____ _____

Parent/ Guardian Signature Date

_____

Printed name

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Observation Policy

At Way to Grow, we value our families and their involvement in their child's plan of care. **However, due to privacy laws, we ask that families remain in the lobby area during sessions, unless there are private rooms available and scheduled prior to your child's session.** All observed interactions of other patients and therapists are to remain confidential to abide by HIPAA regulations.

Observations of sessions are provided to allow for opportunities for parent education, home program training, and interactive participation with your child and therapist. Therefore, the following guidelines must be adhered to during observations:

- ❑ No siblings in session areas unless in observation room
- ❑ Refrain from use of technology (cell phones, laptops, tablets, etc)
- ❑ Absolutely NO pictures or videos

For the safety and privacy rights of all of our patients, we ask that you do NOT enter the therapy areas without permission or escort. _____ (Initial).

By signing this I understand the observation policies

_____ _____

Parent/ Guardian Signature Date

_____

Printed Name

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Photo/Video Release Form

At Way to Grow, we work on fun activities and enjoy sharing these with the community. We also want to share activities that you can use at home. On occasion, pictures, videos, or other recordings may be taken during/after therapy sessions to be shared on Way to Grow Pediatric Therapy social media platforms (including but not limited to: Facebook, Instagram, or Twitter), for use in educational or promotional materials, or on the Way to Grow website to promote the practice and benefits of therapy sessions. No personal identifiable information will be shared on social media or on our website. No compensation will be provided for use of your child's photo or video recording. Upon signing and choosing a selection, you agree that you have read the above statement, understand the ways in which media may be shared, and understand the terms.

Please choose a selection below (initials):

_____ **I DO allow media to be taken and shared of my child**

Any specifications? (no face shown, picture only, etc.) _____

_____ **I DO NOT allow any pictures, video, or voice recordings to be taken or shared of my child**

Parent/Guardian Signature _____ **Date** _____

Child's Name _____

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Authorization for Credit Card Payment

I, _____ hereby authorize, Way to Grow, LLC, to charge my credit card for all services and fees rendered.

Credit Card Information

- ☐ Visa
- ☐ Mastercard
- ☐ American Express

Card Number: _____

Expiration Date: _____ Security Code _____

Name on Card: _____

Billing Address: _____

By signing this form, I acknowledge the charges described in the Way to Grow Policies and take full responsibility for said charges. If my card changes, expires, or is terminated, I agree to notify and update Way to Grow with the new credit card information when obtained. A new form will need to be completed and will be stored electronically in our secure online system (EMR).

_____ _____
Signature of Parent or Personal Representative Date

_____
Printed Name of Patient Represented

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Patient Insurance Responsibility and Consent Agreement

Blue Cross Blue Shield Only

Health Insurance: _____

Benefits Phone Number: _____

Patient's Name: _____ Patient's birth date: _____

Patient's address: _____

Physician/Pediatrician: _____ Phone: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's Address: _____

Policy Holder's Phone:_ _____ Employer:_____

Member ID :_____ Policy Group Number: _____

Insurance Verification

It is the Member's Responsibility to:

- know the insurance policy. Be aware of the benefit coverage prior to the appointment regarding covered and non-covered benefits, authorization requirements, deductibles, coinsurance and copays. ***You must contact your carrier directly to obtain this information.***
- Any non-covered services are the financial responsibility of the patient.
- Any billable amount from Way to Grow that is a non-covered benefit will be patient responsibility unless, stated otherwise per your insurance company.
- To notify Way to Grow if the insurance requires a progress report or any other documentation for authorization. ***We require a minimum of 2-week notice, prior to authorization date/renewal.***
- Obtain name of Insurance Representative and Reference number you speak with.

OT / ST / PT Effective Date:_____ Calendar / Plan Yr:_____

Referral / Script Needed: Yes No Authorization Needed: Yes No

CO PAY: Yes No _____ Deductible: Yes No Ind:_____ Family:_____

Amount Met Ind:_____ Family:_____

Coin Ins: 90 /10 80/20 70/30 Other:_____

Out Of Pocket Max Ind:_____ Family:_____

Amount Met Ind:_____ Family:_____

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Visit / $ limit: _____ Used:_____ HARD / SOFT OT / PT / ST

_____ Used:_____ HARD / SOFT OT /PT / ST

_____ Used:_____ HARD /SOFT OT /PT / ST

INSTRUCTIONS FOR SOFT LIMIT:_____

Name of Representative:_____ Reference #:_____

Patient Insurance Responsibility and Consent Agreement

Blue Cross Blue Shield Only

It is Way to Grow's Responsibility:

- To file insurance claims on the patient's behalf. Way to Grow will file a claim with Blue Cross Blue Shield.
- Way to grow will verify effective coverage and will notify the policy holder of any issues once insurance has been billed.
- **Way to Grow is not responsible for providing insurance coverage and benefit information to patients.** As a courtesy, the WTG Billing Department is available to assist you with your questions.

I authorize the release of any medical or other information necessary to process claims. I also request payment of benefits to Way to Grow LLC, for services provided and claimed. All checks/payments made to member on behalf of their insurer for therapy services provided to their child/family will be provided Way to Grow within 5 business days of receipt. _____ (initial)

Deductibles: A $65.00 fee toward your deductible will be collected at the time of service. Once we receive an EOB back from your insurance company, we will then run the remaining deductible balance to your card on file. For those that do not have a card on file, we will collect any remaining deductible balance at your next appointment. _____ (initial)

Co–Insurance: We will not be collecting co-insurance at the time of service. We will run the card on file or collect your payment once we receive the EOB back from your insurance company at your next scheduled visit. _____ (initial)

I understand a quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service. **I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.** _____(initial)

Way to Grow, LLC will submit claims to your primary (in-network) insurance for all services it provides to your child. However, if Way to Grow, LLC does not receive payment from your insurance provider within

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60 days of submission OR your insurance notifies Way to Grow, LLC that the services provided are not covered under your insurance plan (e.g. services not included in your benefits, not pre-authorized or not deemed medically necessary), **you agree to pay Way to Grow, LLC the outstanding balance for all services provided due at the time of service. In addition, any accrued fees are also due prior to your child's scheduled session.** Way to Grow, LLC will bill you for the amount due., and payment will be due upon receipt of billed amount. _____(initial)

Any balance on your account that is more than 60 days old may cause your account to become delinquent and a collection process will be initiated. If Way to Grow eventually receives payment from your insurance, Way to Grow, LLC will refund you the difference. ****Way to Grow, LLC is in-network with BCBS only. NO EXCLUSIVE BCBS Plans****

_____
Initial Here

Collection proceedings

If your account becomes delinquent, you agree to pay Way to Grow, LLC for any expenses Way to Grow, LLC incurs to collect on your account, including reasonable attorney fees and collection costs.
I fully understand that if my account becomes delinquent, and I don't settle my outstanding bill, Way to Grow, LLC will turn the amount over to a collection agency.

Binding Nature

You hereby agree that this Agreement is binding upon you and your estate, executors and/or administrators, if applicable.

Questions

You acknowledge and agree that you understand the terms of this Agreement and that Way to Grow, LLC has answered, to your satisfaction, any questions regarding your obligations under this Agreement.

_____ _____
Signature of Financial Responsible Party Date

_____
Printed Name of Financial Responsible Party