Attention Parents

Upon completion of this packet,

Please mail to:

The Children's Therapy Center, Inc.

310 Odyssey Drive

Webster, TX 77598

OR

Fax to: 281-480-5691

OR

Email to: dkenney@tctci.com

You can also call us with any questions at 281-480-5648

***When faxing or emailing, please save the original packet forms and bring them to your first appointment**

Once we have received your packet, we will then confirm receipt of the information and call you to go over placement availability.

Thank You

THE CHILDREN'S THERAPY CENTER, INC.

2023 Forms

Dear Parents,

Thank you for inquiring about *The Children's Therapy Center, Inc.* Enclosed you will find information about the therapies provided at our clinic, a medical questionnaire to be filled out regarding your child, a client info/insurance form, our cancellation policy and a brief letter suggesting clothing appropriate for evaluations and treatment sessions.

For the cost of evaluations and treatment please call the office. Evaluation times may vary depending on the client's needs.

Treatment sessions: Speech Therapy sessions range from 30-60 minutes. Occupational Therapy sessions are 55 minutes in duration. Both therapies are scheduled weekly based on the client's needs. Occupational Therapy also provides intensive therapy programs to address treatment goals. These sessions may be scheduled 3 to 5 times per week. Price of therapies depends on length of time, insurance coverage or self-pay options. Please ask our office about the different programs.

We require full payment at the time of service, unless we are a network provider for your insurance company, in which case your co-payment, co-insurance and deductibles are due at time of treatment. Your insurance contract is between you and your insurance company, and you are fully responsible to us for the total amount of the fee should your insurance company fail to pay. Our practice is committed to providing the best treatment for our clients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We will call and verify your benefits; however quoted benefits are not a guarantee of payment. The standard disclosure from the insurance companies is that there is no guarantee of payment until the claim is filed. If we are not in network with your insurance company, *The Children's Therapy Center, Inc.* is happy to provide a statement for you to file for out-of-network benefits if available in your policy.

You will receive a complimentary copy of each evaluation. A fee will be charged for additional copies.

Please check out our website at www.TCTCI.com for more great information about our staff and services. You can also find us on Facebook and like us on Google.

Sincerely,

Dr. Susan H Zapf

Dr. Susan Zapf, Ph.D., OTR, BCP, ATP
Owner/Director of Clinical Therapy

_____ _____ _____

Parent/Guardian Signature Date Child's name

THE CHILDREN'S THERAPY CENTER, INC.

2023 Forms

CLIENT'S NAME _____
(LAST) (FIRST) (MI)

DATE OF BIRTH _____ **SEX** _____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

PRIMARY CARE PHYSICIAN _____

PHONE # _____ **FAX #** _____

Father/Guardian's name _____ **Phone #**_____**Preferred Contact Y/N**

Marital Status _____ **Father/Guardian's Email** _____

Mother/Guardian's name _____**Phone #**_____**Preferred Contact Y/N**

Marital Status _____ **Mother/Guardian's Email** _____

Emergency Contact _____ **Relationship** _____ **Phone #** _____

REFERRED BY _____ **PHONE#** _____

PRIMARY INSURANCE INFORMATION

POLICY HOLDER'S NAME _____ **SEX (Policy Holder)** _____

Employer (Policy Holder) _____

DOB (Policy Holder) _____ **Relationship to insured (client)** _____

PRIMARY INS. CO. _____ **PHONE #** _____

POLICY HOLDER'S ID# _____ **GROUP #** _____

HMO _____ **PPO** _____ **POS** _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO *THE CHILDREN'S THERAPY CENTER, INC.*
I AUTHORIZE MEDICAL NOTES TO BE SENT TO INSURANCE WHEN REQUESTED.
FOR THOSE WHO ARE SELF-PAYING, PLEASE ALSO SIGN AND DATE THIS FORM IN THE SPACE BELOW.

_____ _____

(SIGNATURE OF PARENT/GUARDIAN) **(DATE)**

THE CHILDREN'S THERAPY CENTER, INC.

CLIENT MEDICAL QUESTIONNAIRE

Date: _____

What type of therapy are you interested in? ☐Occupational Therapy ☐Speech Therapy

PREFERRED SCHEDULE FOR SET WEEKLY APPOINTMENT TIME: (Circle all that apply)

Day:	Monday	Tuesday	Wednesday	Thursday	Friday
Time:	AM/PM	AM/PM	AM/PM	AM/PM	AM/PM

Availability Notes: _____

Child's full name: _____
School:_____ Grade:_____
Birthdate:_____ Sex: ☐Male ☐Female
Diagnosis (if any): _____
Receiving any therapy services currently? Yes ☐ No ☐
If so, what are they?_____ Where?_____
What are your concerns for your child? (Academic, personal, social)
_____
_____

Motor Development:
Does any of your child's motor development seem to be delayed?

		Yes	No
Gross Motor & Motor Planning	a. Moving through space/environment		
	b. Jumping, hopping, skipping		
	c. Seem clumsy (or did they ever)		
Fine Motor	a. Holding a pencil		
	b. In-hand manipulation of small objects		
	c. Managing a fork/spoon/knife		
Self Help	a. Dressing		
	b. Tying shoes (if age 6 or older)		
	c. Feeding self		
	d. Drinking from cup with lid		
	e. Bathing self/wash hands		
	f. Manipulating fasteners		
	g. Brushing teeth		
Executive Function	a. Organizing for task		
For ages 8 and up	b. Problem solving		
	c. Able to carry multiple objects		
Sensory	a. Bothered by brightness, loudness, clothing tags & seams, teeth or hair brushing		
	b. Doesn't clue into surrounding environment-bumps into others/walls/face messy & doesn't notice		

Language Development:

1. Has your child evidenced any problems with his/her speech such as delayed development, articulation (production of sounds), fluency (stuttering), or voice?

   If yes, explain_____
   _____
   _____

Social:

1. How does your child get along with friends? _____
   _____

Feeding:

1. Is feeding an area you want addressed in Occupational Therapy?
   Yes ____ No_____
2. Does your child avoid certain textures? Yes_____ No_____
3. Does your child gag when eating or swallowing? Yes _____ No_____
   If yes explain:
   _____
   _____
4. Does your child gag with the smell of foods? Yes _____ No _____
5. Has your child had a swallow study? Yes_____ No _____
   If yes, what were the results:
   _____

Behavior/Character:

1. Have there been specific behavior problems in the course of your child's development?_____
   _____
   _____
2. Please add any other comments you might have regarding your child's behavior and character:_____
   _____

Summary:

You have been asked several questions that will help us better understand your child's needs. Please feel free to describe any other areas of concern.

_____
_____
_____
_____

THE CHILDREN'S THERAPY CENTER, INC.

CANCELLATION POLICY: 2023

Consistency in weekly therapy sessions is crucial to your child's progress towards their treatment goals; therefore, we strive to provide your child's weekly scheduled therapy sessions at their designated time. For our part, we will work to reschedule missed appointments and provide substitute coverage by other trained therapists at our clinic when your therapist must cancel. We do not overbook our sessions, as we focus on providing quality therapy to each child we treat, along with providing therapy in a timely manner.

____ We ask that you consider your part in this treatment partnership for your child. If you must cancel a session, we require a 24-hour notice so that your therapist can adjust their schedule and offer the opening to another child that may need therapy that week. A full session fee will be charged for missed appointments unless we have a 24-hour notice. **Insurance will not pay for missed appointments**. If your history of attendance has been good; we will take extenuating circumstances into consideration.

____ When your therapist will be out and has another therapist sub for your regular session time, TCTCI expects your child to attend the therapy session. We want your child to continue the therapy we have recommended. All of our TCTCI therapists are highly trained and can provide services to your child.

____ If you are over 15 minutes late to your appointment or need to leave 15 minutes early, you will be charged for the time you missed. With the changes in healthcare and specific time constraints on billable units, we cannot charge insurance companies for the time you miss. We also ask that if you leave the clinic during your child's treatment that you return at least 5 minutes prior to the end of your child's session so the therapist can discuss the treatment session and any recommendations for home program.

____ Planned absences or lapses in insurance coverage of more than two weeks (or more than one week for clients seen every other week) may result in the loss of your appointment time. Missed sessions accounting for more than 15% of your scheduled sessions may also result in a loss of your appointment time. This percentage will be reviewed on a quarterly basis. We will work to keep your time but this cannot be guaranteed. Our goal is for your child to receive consistent therapy in order to achieve their best outcome.

We consider our relationship with you a partnership. We pride ourselves on our family-friendly attitude and on providing high quality therapy. We promise to keep up our part of the relationship and hope you will do the same.

Dr. Susan A Zapf

Dr. Susan Zapf, Ph.D., OTR, BCP, ATP
Owner/Director of Clinical Therapy

_____ _____

Parent/Guardian Signature Date Child's name

THE CHILDREN'S THERAPY CENTER, INC.

2023 Forms

Dear Parents,

It is important that you understand that the type of therapy applied at *The Children's Therapy Center, Inc.* can involve hands-on therapy, as we are looking at muscle movement and muscle tone. Sometimes the removal of some clothing is needed so the therapist can visually assess muscle contraction and tone and provide tactile facilitation of the muscle. Often a therapist will apply hands to muscles or muscle groups to facilitate activity in these muscles or to support weak muscles.

For the evaluations, please have your child dressed in clothing that will allow the therapist to visualize muscle groups. The removal of their shirt, shoes and socks is optimal but difficult for some children. Shorts and a tank top might be a good alternative.

If the removal of clothing or touch by therapists (for the purpose of evaluation and treatment) is unacceptable to you, please make that known at your first visit.

It is a good idea to wear washable clothing during treatment. This is due to the possibility of working with paints, shaving cream, etc. and clothes may become soiled.

If you understand the necessity of touch and occasional removal of parts of clothing (for the purpose of evaluation and treatment), and agree that this is permissible, please sign and return.

Thank you,

Dr. Susan A Zapf

Dr. Susan Zapf, Ph.D., OTR, BCP, ATP
Owner/Director of Clinical Therapy

_____

Parent/Guardian Signature Date

_____

Child's name