

Attention Parents

1. Please complete the following forms.
2. These are PDF fillable forms so you can complete on your computer or download and print to complete.
3. Upon completion of this packet, please return to TCTCI

- mail to:

The Children's Therapy Center, Inc.

310 Odyssey Drive

Webster, TX 77598

- OR Fax to: 281-480-5691
- OR Email to: kkilpatrick@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 as we need to have the original signature.**

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

Thank You, TCTCI Office Staff



THE CHILDREN'S THERAPY CENTER, INC.

2024 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 A. Zapf, Ph.D., OTR/L, BCP, ATP

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.

2024 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			
	b. Problem solving			
For ages 8 and up	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		

Client's Name _____
DOB _____

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 2024:

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 and 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 needs therapy that week. If we do not receive a 24-hour notice, a cancellation fee for missed business opportunity will be charged. The fee for a 60-minute session- \$100.00, 45-minute session- \$75.00, 30-minute session - \$50.00. **Insurance will not pay for a missed appointment.**

TCTCI requires a 2-week notice if you are deciding to end your child's therapy services without recommendation from your child's therapist. This allows the therapist to put together recommended activities for home program and to provide time for closure with your child.

There are times when your primary therapist will be out due to vacation, illness, or training. TCTCI will work to provide another therapist to treat your child's session. When another TCTCI therapist is available for your regular session time, TCTCI expects your child to attend their therapy session. TCTCI embraces a "**flexibility model**" so that your child will continue to receive the needed therapy recommended in your plan of care. Flexibility is a key life skill that will help your child learn to adapt and gain skills in working with others. All therapist at TCTCI are trained and practice this flexibility model. We will no longer allow refusal of a sub therapist, unless your primary therapist feels your child cannot adapt.

If you are over 10 minutes late to your appointment or need to leave 10 minutes early, you will be charged for the time you missed. With the changes in healthcare and specific time constraints for billing, 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. Our goal is for your child to receive consistent therapy to achieve their best outcome, and attendance is a key to success.

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

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.

2024 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, Ph.D., OTR/L, BCP, ATP

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

Parent/Guardian Signature Date

Child's name