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: intake@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.

2025 Forms

Dear Parents,

Thank you for inquiring about *The Children's Therapy Center, Inc.* To start our intake process, we need you to complete the attached forms (Information sheet and Client Medical Questionnaire). Once we receive these items, we will start the intake process for therapy services and place your child on our therapy services list. The intake process involves many steps that include finding a scheduled time with the therapist that will meet your child's needs, insurance verification, and completion of medical history and clinic forms that will be given to you prior to the time of your scheduled evaluation.

To schedule an evaluation, we require a $100.00 deposit to secure your initial appointment. This deposit will go towards the cost of the evaluation or reimbursed if your insurance covers the evaluation cost. However, if you do not show for your scheduled evaluation or cancel less than 24 hours prior to the appointment, this deposit will be used towards the cancellation fee for missed session. Therapy evaluation costs vary based on your child's need and time spent for services. Evaluation times may vary depending on the client's needs. For the cost of evaluations and treatment please call the office. You will receive a complimentary copy of each evaluation. A fee will be charged for additional copies.

Treatment sessions: Speech Therapy sessions range from 30-45 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 based on the program. 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.

Please check out our website at www.TCTCI.com for more great information about our staff and services. You can find us on Facebook and like us on Google. We look forward to treating your child and family.

Sincerely,

Susan A. Zapf, Ph.D. OTR, 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.

2025 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.

_____
_____
_____
_____