

# **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](mailto: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.

**2026 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](http://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,

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.

2026 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		
	a. Bothered by brightness, loudness, clothing tags & seams, teeth or hair brushing		
Sensory	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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_