SOH PEDIATRIC THERAPY CENTER

4908 S. Sheridan Road
Tulsa, OK 74145
Phone: (918)984-9153
Fax: (918)289-0579

CLIENT AGREEMENT

Soaring on Hope maintains a strong commitment to providing quality, result-oriented therapy services to children. We ask that all families share in our commitment by playing an active role in the therapy process to ensure the best possible outcomes for your child. PLEASE INITIAL EACH OF THE STATEMENTS BELOW TO GIVE YOUR CONSENT.

Consent for Services

☐ I authorize Soaring on Hope to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by qualified, licensed, and trained health professionals. I recognize, agree, and understand that I have the right to refuse treatment or terminate services at any time notifying Soaring on Hope in writing. In addition, Soaring on Hope may terminate services by notifying me in writing.

Authorization for Medical Treatment

☐ Office Practice/Clinic personnel at this clinic are hereby authorized to administer any medical, diagnostic, or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency, or extraordinary circumstances.

Observation/Assisting Release

☐ I understand that SOH participates with local colleges, universities, and interested volunteers in allowing observation and assisting experiences within therapy sessions. These individuals are counseled prior to their observation and/or therapy assisting activities regarding confidentiality of patient information and agree to abide by SOH policies on confidentiality as part of their observation and assisting experiences.

Media Release

☐ Accept

PICK ONE

I hereby **GIVE PERMISSION AND CONSENT** to all staff of Soaring on Hope to photograph, videotape and/or audiotape my child and/or myself during the time my child is enrolled in services. I give my permission and understand these photographs, videos and/or audiotapes will be used according to the therapist's discretion which could include, but not limited to, video modeling and other educational interventions, training for parents and/or staff, social media, website, and other promotional materials. Soaring on Hope will not disclose any of my child's personal information.

☐ Decline

I hereby **DO NOT GIVE PERMISSION AND CONSENT** to all staff of Soaring on Hope to photograph, videotape and/or audiotape my child and/or myself during the time my child is enrolled in services.

Hold Harmless

☐ In consideration of Soaring on Hope LLC furnishing services and/or equipment to enable my child to participate in activities, I agree as follows:

I, on behalf of myself, my personal representatives, and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Soaring on Hope LLC and its owners, agents, officers, and employees from any and all claims, actions or losses for bodily injury, property damage, loss of services or otherwise which may arise from my child's participation in activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE IT IS MY INTENTION TO INDEMNIFY AND HOLD HARMLESS SOARING ON HOPE LLC FROM LIABILITY FOR PERSONAL INJURY OR PROPERTY DAMAGE CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

HIPAA Privacy Notice Acknowledgement –

☐ I understand that my child's and/or my medical records and billing information are made and retained by Soaring on Hope and are accessible to office personnel. Clinic personnel may use and disclose medical information for therapy treatment, counseling, functions and to any other physician or health care personnel involved in my child's and/or my continuum of care. Safeguards are in place to discourage improper access. Soaring on Hope and its staff are authorized to disclose all or part of my child's medical record to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of the Office/clinic's charges and to any health care provider who is or may become involved with my care. Oklahoma law requires that SOH advise you that the information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease, related to mental health, drug, substance or alcohol abuse. By signing this agreement, you are consenting to such disclosure.

☐ A complete description of how your medical information will be used and disclosed by SOH is in our Notice of Privacy Practices (HIPAA). A copy is posted in this Office/Clinic. I was asked if I would like a copy of the Notice of Privacy Practices (HIPAA) form, and/or have received a copy of the Notice of Privacy Practices (HIPAA) form.

Release of Protected Health Information - Information will **ONLY** be released to the following individual(s): Please list yourself. Include type of access ALL or LIMITED. If limited, please be specific. Ex: Individual can drop off, pick up, make changes to schedule, and collaborate with therapist before and or after therapy, regarding child. Giving ALL access means all the above will be allowed.

Name	Relationship to Patient	Type of Access to patient	Phone #

Communication preference

ACCEPT DECLINE

☐ ☐ I grant permission to provide me with written communication via HIPAA complaint encrypted email service via my email provided on the patient demographics form.

☐ ☐ I grant permission to provide me with written communication via text message to my cell number which was provided on the patient demographic form. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

☐ ☐ I grant permission for Soaring on Hope to leave relevant medical information on my voicemail.
I understand it is my responsibility to inform the clinic of changes to my preferred contact information or my communication preferences, as well as, to revoke the above authorization at any time.

I hereby certify that I have read and initialed each of the above statements, have had each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original. This entire consent is valid from the date of my signature until closure of patient file or until I revoke it in writing which can be done at any time, without penalty.

Child's Name (please print) _____ Child's Date of Birth _____

Legal Guardian Name(please print) _____ Relationship to Child _____

Legal Guardian Signature _____ Date Signed _____

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Occupational, Physical, and Speech Therapy Intake

Client _____ Client's DOB_____

Guardian_____ Relationship to client_____

Has your child **NOW** or **PREVIOUSLY** received any of the following therapies?

	YES	NO	DATE OF LAST SERVICE	NAME OF LOCATION
Physical Therapy				
Speech/Language Therapy				
Occupational Therapy				
Behavioral Health Services				
ABA Therapy				

PRENATAL and NEONATAL HISTORY

Childs Birth Weight_____lbs._____oz.

	Y	N
Full Term		
Vaginal Delivery		
Cesarean Section		
Any unusual stress		
Surgery		
Extended hospital stay		
NICU stay		
Incubator		
Oxygen		

_____Weeks

Please list details.

_____

_____

_____

_____

_____

MEDICAL HISTORY

Major illness_____

Chronic health condition _____

History of Ear Infections _____

Any other health problems during infancy_____

DEVELOPMENTAL MILESTONES

Please approximate on age and write WNL for "within normal limits"

Roll_____ Belly crawl_____ Walk_____

Sit_____ Crawl on hands/knees_____

TELL ME ABOUT YOUR CHILD

What kinds of things does your child enjoy? _____

_____

What things about your child do you especially enjoy? _____

_____

PERTINENT INFORMATION

Are child's parents married/divorced? _____
Who does the child live with? _____
Siblings? _____

When did parents become concerned about behaviors?

_____

Do they have frequent meltdowns? Yes _____ No _____ Is your child aggressive? Yes _____ No _____
What triggers them? _____ How long do they last? _____

What do your child's meltdowns look like? _____

_____

What calms them down?

_____

PLAY-SOCIAL SKILLS

Describe the play activities your child engages in _____

_____

Does your child play interactively with his/her peers? Yes _____ No _____
Does your child make friends? Yes _____ No _____ Can your child maintain relationships? Yes ____ No ____
Does your child have friends in school/daycare and/or outside of school/daycare? Yes _____ No _____
Does your child play independently? Yes _____ No _____

ACADEMICS

Is your child attending any of the following? What is the name of the place they attend?

	YES	NO	All Day	Half Day	In Person	Distance	Name of Daycare /School
Daycare							
Preschool							
Elementary							
Middle School							
High School							
Home School							

Any difficulties/areas of concern in daycare or school? Please describe: _____

_____

_____

Is your child on an IEP or IFSP? Yes _____ No _____ If yes **PLEASE BRING THE MOST RECENT COPY**

Where Hope takes flight

SENSORY

Do any difficulties arise when your child is in stores, malls, restaurants, etc.? (such as uncontrollable touching, sensitivity to noises, lights) Yes _____ No _____

Does he become over stimulated by the activity around him/her? Yes _____ No _____What response does he/she have to overstimulation? _____

SPEECH / LANGUAGE QUESTIONNAIRE

Are you wanting your child to receive Speech/Language Therapy? **YES** **NO**

If yes, please complete the following. If no, you can **move to the next section.**

Why are you seeking speech/language therapy services for your child?_____

_____

When was the problem first noticed? _____

_____

Is the child aware of the problem/s? **YES** _____ **NO** _____

What Language(s) are spoken in the home? _____

If more than one, which does the child prefer to use? _____

Does the child speak the language? **YES** _____ **NO** _____ Does the child understand it? **YES** _____ **NO**_____

How does your child usually communicate?

Gestures _____ Sign Language_____ Single Words _____ Short Phrases _____ Sentences _____

Please describe: _____

_____

Does your child

Responds to sound	YES	NO
Responds to name being called	YES	NO
Follow simple directions	YES	NO

Responds to sound inconsistently	YES	NO
Ignores sounds willfully	YES	NO
Responds correctly to yes/no	YES	NO

Responds correctly to "wh" questions (who, what, when, where, why)	YES	NO

Has your child ever had a hearing screening/eval? **YES** ____ **NO** ____

When? _____ Results? _____

Where was the screening/eval done? _____

Phone# _____ Fax# _____

PHYSICAL THERAPY QUESTIONNAIRE

Are you wanting your child to receive Physical Therapy? **YES** **NO**
If yes, please complete the following. If no, you can **move to the next section.**

Why are you seeking physical therapy services for your child?

_____

When was the problem first noticed?

_____

Is the child aware of the problem/s? Yes _____ No _____

Does your child complain of pain? Yes _____ No _____

If yes please describe the type and frequency. _____

_____

Does your child appear to participate in age appropriate play and movement activities (e.g. riding a bike, skipping)
Yes _____ No _____

OCCUPATIONAL THERAPY QUESTIONNAIRE

Are you wanting your child to receive OCCUPATIONAL THERAPY? **YES** **NO**
If yes, please complete the following. If no, you can **move to the next section.**

Why are you seeking occupational therapy services for your child?

_____

When was the problem first noticed? _____

_____

Is the child aware of the problem/s? **YES** _____ **NO** _____

Does your child do better with a structured routine? **YES** _____ **NO** _____

Describe what happens if the routine is altered

_____

_____

_____

SLEEP

What time does your child go to bed? _____ Wake up? _____

Does your child have problems falling asleep? **YES** ____ **NO**____
Do they wake up frequently at night?
Does your child have difficulty waking up in the morning? **YES**____ ____

OCCUPATIONAL THERAPY QUESTIONNAIRE – continued

ACTIVITIES OF DAILY LIVING

(please state whether your child can perform the following activities independently (i) or needs help (nh):

PERSONAL CARE	Independently	Needs Help
Toileting		
Brushing Hair		
Bathing		
Brushing Teeth		

DRESSING	Independently	Needs Help
T-Shirt		
Shirts w/ Buttons		
Pants		
Socks		
Shoes		
Tying Shoes		
Jacket		

How long does it take your child to get dressed? _____

Can your child pick out an appropriate outfit? Independently or Needs Help (Circle One)

FEEDING	Independently	Needs Help
Use Cup		
Use Fork		

	Independently	Needs Help
Use Spoon		
Use Knife		

Is your child able to manage utensils including pencils, crayons, forks, spoons, and knives?
Yes _____ No _____ If no, please describe: _____

Does your child use a standard tripod grip?
Yes _____ No _____ If no, please describe: _____

Is your child RIGHT _____ handed LEFT _____ handed or Not Established_____?

ADDITIONAL INFORMATION

Parents, thank you for providing this information. It will assist us in determining the most appropriate evaluation tools and treatment when establishing therapy goals and monitoring progress.

Now, let's pretend that therapy is over, and you are deciding whether treatment was successful. What are 5 or so changes that would make you say "Yes, that was worth the time, money and effort we put into it."

_____

_____

_____

_____

Is there anything else that you would like us to know about your child, you or your family that will help us support all of you through this journey?

_____

_____

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Participation Policy for Speech, Occupational, and Physical Therapy Services

For safety reasons, Soaring on Hope requires that a guardian or parent of each client **remain on premises during treatment unless that client is scheduled for more than 4 hours of treatment during that day**. If you would like to leave the waiting room, but not leave the premises, you must check in at the reception window and confirm we have updated contact information for you. In the event you do leave and are not on premises to pick up your child at the end of the appointment, the appointment may be counted as a no-show appointment.

Client appointments will be on a recurring schedule based off the therapist's plan of care. We respect our client's and therapist's time and will make every effort to see you on your scheduled appointment date and time. We will also make every effort to notify you in advance if we should have to change or reschedule your appointment due to unforeseen circumstances. IN ORDER FOR THERAPY TO BE BENEFICIAL, CONSISTENT ATTENDANCE IS CRUCIAL.

Consent for Services.

PLEASE INITIAL EACH OF THE STATEMENTS BELOW TO GIVE YOUR CONSENT.

ATTENDANCE RATE- Consistent attendance contributes to effective progress. We expect an attendance of at least 85%. I understand that if the rate falls below 85% my child will be removed from the recurring schedule. To continue with therapy, I will need to call in weekly to schedule my child's appointment. If I am unable to maintain an attendance rate of 85% while on the weekly call- in program, my child could be discharged from therapy services at SOH.

NO SHOW -– Any appointment that is missed without prior notice given.

I understand that after 2 no showed appointments my child will be removed from the recurring schedule. To continue with therapy, I will need to call in weekly to schedule my child's appointment.

UNEXCUSED ABSENCE– Any absence that is not cancelled 3 hours in advance.

I understand that excessive unexcused absences will affect my child's attendance rate as well as cause the insurance provider to reduce or not approve authorization required to continue services.

Tardy– Not arriving on time for the scheduled appointment.

I understand that if I am more than 15 minutes late for my child's appointment, the appointment is not guaranteed. If I arrive late and still able to see the therapist; I am not guaranteed a full session. Excessively being late can mean that my child is removed from the recurring schedule and placed on the weekly call-in program.

I hereby certify that I have read and initialed each of the above statements and understand the participation policy.

Print Parent Name _____ Parent/Guardian Signature _____ Date _____

Child's Name _____

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FINANCIAL POLICY

INSURANCE BENEFITS QUOTE POLICY

As an added service to you, Soaring on Hope will request insurance Benefit Quotes and Eligibility verification from your insurance provider. ***This is not a guarantee of coverage or payment.*** Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts such as deductible may change as additional claims are processed.

I understand that Soaring on Hope will assist with insurance precertification requirements but will not assume responsibility for precertification or any impact which it may have on insurance payment.

Please understand, if your insurance only allows a limited number of visits, it is your responsibility to keep track of visits as used.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to include major medical benefits to which I/my child am/is entitled, including Medicaid, private insurance, and third-party payers to ***Soaring on Hope.*** I hereby authorize said assignee to release all information necessary for processing. I authorize provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

It is policy to view fees for professional services as a charge to the client, not the insurance company. All co-pays and deductible amounts are due at time of service. As a courtesy to you, we will file your health insurance claim for the remainder of the charges with our in-network insurance companies. If you do not have insurance, it is expected that all fees be paid as services are rendered.

If claims are not paid or denied within 60 days, you are responsible for the account balance due. Payment of your portion is expected upon receipt to continue ongoing therapy sessions or services. You will be responsible for negotiating any disputed claims with your insurance company and to insure regular payment on your account. For your convenience, you may pay with cash, check, or credit card. If there is an overage on your account, it is suggested that the difference be credited to your account toward future treatment or refunded to you if therapy is complete.

Insurance will only pay for 1 evaluation per therapy service every 6 or 12 months. (181 /365 days) If your child has previously received an evaluation within 6/12 months, we will need a copy of that evaluation report. If you fail to mention that your child has already received an evaluation and insurance denies payment, you will be held responsible for the full payment amount.

_____

I have read and understand the Financial and Health Insurance Policy Statement of ***Soaring on Hope*** *and am agreeable to all the policies stated. I understand my responsibility for full payment on my account.*

I understand that if Insurance/Medicaid fails to pay for my child's evaluation since Insurance has already been billed for an evaluation in the past 6 or 12 months then I will be held responsible for the full amount of the cost of the evaluation. (Approx. $150)

I understand there will be a $30 NSF fee for all insufficient funds checks.

I understand if I have Private and/or Medicaid Medical Insurance and become ineligible, I will be responsible for any payments incurred during the ineligibility period.

Child's Name (please print)	Child's Date of Birth
Legal Guardian Name (please print)	Relationship to Child
Legal Guardian Signature	Date Signed

7/15/21-JA