CSTC Therapies Inc.

OCCUPATIONAL & PHYSICAL THERAPY
PATIENT REGISTRATION FORM

PATIENT INFORMATION DATE:

CHILD'S NAME: ____
LAST FIRST MI

DATE OF BIRTH: ______-_____-_______ SEX: M F

ADDRESS:______________________________CITY:_________________STATE:__________ZIP:_______

SCHOOL: _______________________________ GRADE/CLASS: _________________________________

TEACHER: ______________________________

LANGUAGES: English (%) ; _________________ (%) ; _______________ (%)

DIAGNOSIS:_____________ PRECAUTIONS/CONTRAINDICATION FOR THERAPY__________________

ANY KNOWN ALLERGIES, IE FOOD, LATEX…____

HOW DID YOU HEAR ABOUT US? Dr._____Website_____Friend_____Phonebook._____Ad_____Other_____

PARENT/LEGAL GUARDIAN

NAME:____SEX: (M F) MARITAL STATUS:___________
LAST FIRST MI

RELATION TO PATIENT:_________________

ADDRESS:______________________________CITY:________________STATE:_________ZIP:________

E-MAIL ADDRESS:_________________________________ DO YOU CHECK THIS REGULARLY? YES NO

DAY PHONE: (____)_____________EVE PHONE:(____)_____________CELL PHONE:(____)____________

DRIVERS LICENSE: _____________________ STATE: _____ DATE OF BIRTH: _______- _______ - _______

EMPLOYER______________________________ BUSINESS ADDRESS______________________________

NAME:____SEX (M F) MARITAL STATUS:____________
LAST FIRST MI

RELATION TO PATIENT:_____________

ADDRESS: ______________________________CITY:________________STATE:_________ZIP:_________

E-MAIL ADDRESS:_________________________________ DO YOU CHECK THIS REGULARLY? YES NO

DAY PHONE:(____)_____________EVE PHONE:(____)_____________CELL PHONE:(___)_____________

DRIVERS LICENSE: ____________________ STATE: ______ DATE OF BIRTH: _______- _______ - _______

EMPLOYER______________________________ BUSINESS ADDRESS______________________________

21660 Red Rum Dr.,, Suite 105, Ashburn VA 20147
Phone: 703.858.7388 Fax: 703.740.8758 www.cstctherapies.com

CSTC Therapies Inc.

PATIENT'S PRIMARY PHYSICIAN

PHYSICIAN NAME____

PRACTICE NAME:____

ADDRESS:___________________________________CITY:______________STATE:_______ZIP:_________

PHONE: (_______)____________________________FAX: (_______)________________________________

PRIMARY INSURANCE

PRIMARY INSURANCE POLICYHOLDER: ____

RELATION TO PATIENT: __________ BIRTHDATE: _____ - _____ - _____ DRIVER'S LIC.#:____________

INSURANCE COMPANY: ____

ADDRESS:___________________________________CITY:______________STATE:_______ZIP:_________

PHONE: (_______)____________________________FAX: (_______)________________________________

SUBSCRIBER I.D. #: _____________________________ GROUP #: ___________________________________

ACKNOWLEDGEMENTS

HIPAA: Notice of Privacy Practice

By signing this statement you are acknowledging that you have had the opportunity to receive CSTC Therapies Inc HIPAA Notice of Privacy Practices:

PATIENT NAME
(printed):____

Signature:____Date:___________________

Parent/Legal Guardian or self

INSURANCE CERTIFICATION AND RELEASE AUTHORIZATION

This is to certify that I, ___________________________ authorize CSTC Therapies Inc (CSTC) to apply for benefits for services rendered to me or my child by the speech pathologists, occupational therapists, and /or physical therapists at CSTC Therapies Inc. If payment is not made to CSTC for any reason, I understand and agree that I am responsible for payment in full for any/all services that I have received from CSTC Therapies Inc.

I further certify that the information I have provided concerning my insurance coverage is correct. I also realize that confirming coverage of insurance benefits is a courtesy done on my behalf by CSTC Therapies Inc. I understand and agree that I am ultimately responsible for checking with my insurance company/carrier as a follow-up, and that failure to do so may result in a lesser payment or no payment at all.

I understand and agree that any and all referral documentation and or information, if required by my insurance carrier, is MY RESPONSIBILITY to obtain and provide to CSTC Therapies Inc by no later than the date of my appointment.

I further authorize CSTC Therapies Inc to release any information, including medical information for this or any related claims to any insurance company or reimbursing agency in order to determine benefits to which I may be entitled.

I have read, understand, and agree to the above:

____
Signature of Responsible Party

If the patient is under the age of 18, please complete the following:

The undersigned is a parent/guardian of the patient and executes this form on their behalf:

____
Signature of parent/guardian

____
Please print name and relationship to patient

Date form completed: ______________________

PATIENT FINANCIAL AGREEMENT

We are pleased you have chosen CSTC Therapies Inc. for your speech, occupational and physical therapy care. We are dedicated to providing our patients with the best possible care and service, while keeping the costs to you from increasing. We do not render service in order to collect money, but we must collect in order to render service. We ask your help by understanding and cooperating with our financial policy.

We believe that our Patient Financial Agreement is as important as the services that we perform. It is our responsibility to inform you of charges and our payment guidelines prior to treatment. Determining costs for insured patients is more difficult and less accurate. Your insurance is a contract between your employer and an insurance company. Benefits received are based on the terms of the contract negotiated between your employer and the insurance company, and not CSTC Therapies Inc. The goal of insurance policies is to provide basic care and many needed services may not be covered. Our office will do everything possible to help you understand and make the most of your insurance benefits. As a courtesy, our office will complete and submit your insurance forms to achieve the maximum reimbursement to which you are entitled. Please remember that you are ultimately responsible for all expenses incurred. We urge you to read your insurance policy so that you are fully aware of coverage and any limitations of the benefits provided. We will gladly discuss our payment options with you before beginning your treatment.

Insurance:
We participate with certain insurance plans. It is your responsibility to provide us with your correct and current insurance information at the time of your visit and to make sure that we are providers with your specific plan. If you fail to present the correct and current insurance information at the time of your visit, then you agree to be responsible for 100% of our usual and customary charges for your visit.

If we participate with your plan, we will provide the service if filing a claim to your insurance company for office charges, unless we have received prior notification of non-covered services. Those services, along with all co-pays and deductibles are the patient's responsibility and must be paid at the time of your visit. Any fees not billable to insurance will be disclosed in advance, and you will be required to sign a waiver acknowledging our policy before services will be rendered. In addition, you will be given the necessary paperwork to file to your insurance company.

We will file the initial claim to your insurance company. Our office policy is to allow for one subsequent filing. If, after the second filing the claim remains unpaid, then the balance will be transferred to your responsibility and payment will be expected upon receipt of a statement. We will work with you to ensure that our services have been billed correctly, the ultimate responsibility for the timely payment for services rendered is yours. If you are owed a refund, the refund will only be issued when your account balance is zero.

If we do not participate with your insurance, payment in full will be due at the time of your visit.

Payment for services performed:
Our office accepts cash, personal checks, Visa, MasterCard, and American Express. There is a $25.00 fee for co-pays not paid at the time of service, and a $40.00 charge for returned checks. Any patients requiring correspondence via certified mail will be charged a $20.00 fee. All outstanding balances are due within thirty (30) days, unless prior arrangements are made with the billing office. All past due balances are assessed a finance charge of $25.00 per month after sixty (60) days. All balances over 90 days will be sent to a collection agency. You will be financially responsible for all collection and legal fees incurred by CSTC Therapies Inc in the collection of your delinquent balance.

Broken Appointment Policy:

The time for your child's appointment has been exclusively reserved for you and your child. We require that at least 4 hours notice be given, as a courtesy to us and to other patients. **THE BROKEN APPOINTMENT FEE WILL BE $50, UNLESS OTHERWISE NOTED.**

Each family is allowed to cancel the equivalent of one weeks normally scheduled therapy per quarter. Any cancellations beyond this will be charged to you individually since your insurance will not cover the costs of your cancelled sessions. The cancelled sessions will be charged at the normal therapy rate. If the cancelled session is made up within 30 days, it will not be counted as a cancellation and will not be charged.

The patient and/or responsible party has received, read and understand the financial agreement and broken appointment policies. The patient and /or responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with whom this office has a contracted agreement, the patient and /or responsible party agree to pay all applicable co-payments, and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to the patient which is not considered to be covered by insurance.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY SET FORTH BY CSTC THERAPIES INC AND AGREE TO THE TERMS. I ALSO UNDERSTAND THAT THE TERMS OF THIS POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

I have read the above policy and agree to abide by it.

____________________________________ ______________________________

Signature Date

I agree that balances over 45 days be applied to my credit card and that I will be responsible for obtaining insurance reimbursement for any outstanding claims. This consent will remain in effect unless cancelled in writing.

Child(ren)'s name: ____

Name of parent/guardian: ____

Signature: ________________________ Date: ___________________________

Credit Card:_______________ # ______________________________________

Exp. Date: _______________________

Release of information to CSTC Therapies Inc.

By signing below I am giving Children's Speech Therapy Center permission to release information to CSTC Therapies Inc.

____________________________________ ______________________________

Signature Date

MEDICAL HISTORY:	YES	NO
Was mother's condition during pregnancy good to excellent?	____	____
Were medications taken during pregnancy? If yes, what?	____	____
Were there any complications/illnesses during pregnancy? What?	____	____
Was your baby born within two weeks of due date?	____	____
Was your child adopted?	____	____
Were labor and delivery normal?	____	____
Was labor induced?	____	____
Was there evidence of injury or poor health at birth?	____	____
During the first month of life, was child's health good?	____	____
Were there any feeding problems as a baby or toddler?	____	____
Was your child's activity level average as a baby and toddler?	____	____
Does your child have allergies or are allergies suspected?	____	____
Was development of teeth normal?	____	____

**Please comment on any of the above areas that were unusual:

____

____

__

List any additional illnesses, injuries and hospitalizations your child has had, including severity or illnesses and frequency. List any medications that are taken regularly.

____

____

__

Does your child currently have a medical diagnosis? If so, please specify: _____________

DEVELOPMENTAL HISTORY:

Does your child exhibit or has he exhibited any of the following behaviors? If so, please indicate age and any attempts to alter his behavior.

Behavior	*Age*	*Comments*
Excessive Shyness	______________	____________________
Thumb/Pacifier Sucking	______________	____________________
Difficulty separating from parents	______________	____________________
Face Twitching	______________	____________________
Strong Fears/Nightmares	______________	____________________
Temper Tantrums	______________	____________________
Sleep Difficulties or Bedwetting	______________	____________________
Difficulty sitting still	______________	____________________
Inability to complete activities	______________	____________________
Attention Problems	______________	____________________
Compliance with routine activities	______________	____________________

Does your child play well with other children? Do you have any concerns about your child's play?
____
____
__

Does your child have any academic difficulties?
____
____
__

Does your child have any issues that include hearing, touching, smelling, movement, and visual sensitivities or needs?
____
____
__

Does your child currently use any accommodations at home or at school to help them participate in daily life activities? (Visual schedules, sensory diet, equipment use, etc.)
____
____
__

When did your child first achieve the following motor milestones? Please comment on difficulties or concerns.

Milestone	*Age*	*Comments*
Crawling	______________	______________________
Sitting Unassisted	______________	______________________
Walking	______________	______________________
Holding a Cup	______________	______________________
Using a Spoon	______________	______________________
Using Crayons	______________	______________________
Toilet Training	______________	______________________

Does your child have difficulty performing the following tasks? Please comment on difficulties or concerns.

	Yes	No
Putting on/taking off clothing	_____	_____
Manipulating clothing fasteners	_____	_____
Using school supplies	_____	_____
Moving in a coordinated way	_____	_____
Opening containers	_____	_____
Self-feeding	_____	_____

Calming down after an event	_____	_____
Finding objects in messy drawer/book bag	_____	_____
Writing	_____	_____
Reading	_____	_____

ENVIRONMENTAL HISTORY:

Names of Siblings	Birth Dates
____	________________________
____	________________________
____	________________________

Others in the Home ____

Have any other family members or relatives had the following difficulties?

Difficulty	*Yes/No*	*Relationship to Child*
Congenital Muscular Problems	_____	_______________________
Vision Problems	_____	_______________________
Hearing Problems	_____	_______________________
Learning Disabilities	_____	_______________________
Reading Problems	_____	_______________________
Emotional Problems	_____	_______________________
Other	_____	_______________________

PRIOR EVALUATIONS/THERAPY:

Has your child been seen by any other specialists? Yes ____ No _____

Please list any specialists your child has seen for medical, developmental, or educational concerns. Please list current therapists, if any.

____

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____

____

____

Do you have any specific concerns with your child that your would like to see addressed?

____

____

____

____

____

What made you decide to seek occupational therapy services for your child?

____

____

____

____
____

Please add any additional comments or information that we may need to know in order to better serve your child. Thank you.

____
____
____
____
____

**Please return this form along with copies of any previous evaluations, educational plans or other reports you would like us to consider when assessing or treating your child.