Explore Engage Enjoy Pediatric Therapy

Located at 2198 NE Stephens Street Suite 101 Roseburg, OR 97470 phone: 541-900-1418

# REGISTRATION FORM

(Please Print)

| Today's Date: | Referral Date: | Evaluation Date: |
|---|---|---|

## CLIENT INFORMATION

| Client's First Name: | Middle Initial: | Last Name: | Nickname: |
|---|---|---|---|

| Is this the legal name? **Yes** ☐ **No** ☐ | If not, what is legal name? | Birthdate: / / | Sex: (circle one) **M** ☐ **F** ☐ **NB** ☐ |
|---|---|---|---|

| Parent/Guardian Names: | Email: |
|---|---|
| | Primary phone no: ( ) |
| Street Address: | Cell phone no: ( )<br>Work phone no: ( ) |
| P.O. Box: / City: | State: / ZIP Code: |

Who can we thank for your referral?
☐ Dr. _____ ☐ Family ☐ Friend ☐ Other

Other family members seen here:

## PAYMENT INFORMATION

| Person Responsible for Payment: | Birthdate: / / | Address (if different): | Home phone no: ( ) | |
|---|---|---|---|---|
| Occupation: | Employer: | Employer address: | Employer phone no: ( ) | |

**Please bring a copy of your insurance card to the front desk**

Is the client covered by insurance? ☐ Yes ☐ No

| Primary Insurance Company Name: | Policy no: | Group no: | |
|---|---|---|---|
| Subscriber's Name: / Subscriber's SS no: | Subscriber's Birthdate: / / | Co-Payment: $ | Co-Insurance: % |

Client's Relationship to Subscriber: ☐ Child ☐ Other

| Secondary Insurance (if applicable): | Subscriber's Name: | Subscriber's Birthdate: / / | Policy no: | Group no: |
|---|---|---|---|---|

Client's Relationship to Subscriber: ☐ Child ☐ Other

## IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to client: | Home phone no: ( ) | Work phone no: ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the clinician. I understand that I am financially responsible for any balance. I also authorize Explore Engage Enjoy or the insurance company to release any information required to process my claims.

_____ _____

**Client/Guardian Signature** **Date**

## CHECKING YOUR INSURANCE BENEFITS

As a courtesy, we will bill most insurance carriers directly. It is your responsibility to provide correct information for billing your insurance. In order for you to be aware of potential charges to your account in the form of co-pays, co-insurances, or unmet deductibles you are required to check your insurance benefits prior to initial evaluation.

**How to Check Insurance Benefits:**

1. Call the customer service number on the back of your insurance card.
2. Ask the following **bolded questions** to obtain your benefits for Occupational Therapy, Physical Therapy, or Speech Therapy (sometimes these services are called *Outpatient Rehabilitation*)

**What is the individual deductible for my child?**
***If the deductible has not been completely met, the remaining amount will be billed to you, the client, before the co-pay or co-insurance applies.***

Total: _____ Met: _____

**Does the deductible apply for Occupational/Physical/Speech therapy services?**
Yes
No

**What is the out of pocket maximum (OOP)?**

Total: _____ Met: _____

**Once the deductible is met, do I have a co-pay or co-insurance?**
***This is the amount that is due at the beginning of each visit beyond the deductible.***

Co-pay amount: _____ OR Co-insurance percentage: _____

**Is there a visit limit?**
Yes, _____ visits per year and _____ visits are remaining
No

**Does my plan require prior authorization?**
***If the answer is yes, Explore Engage Enjoy will submit the authorization on your behalf. Please be aware that authorizations may impact the scheduling process.***
Yes
No

# PAYMENT POLICY

This is to notify you of Explore Engage Enjoy's office policy for payment and collection of payment. Please read and if you have questions please discuss with our office manager.

**Non Covered Services**

If you choose to obtain the services at Explore Engage Enjoy and they are not covered by your insurance, you agree to be financially responsible for any and all related charges.

**Cancellations and Missed Appointments Policy**

A 24 hour notice is required for all cancellations. This policy is in place out of respect for our therapists and our clients. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule at that time and impact your child's progress. Please note, a $50 no-show fee may be applicable for not attending an appointment without notifying the clinic.

**Primary/Secondary Insurance Billing**

As a courtesy, we bill most insurance carriers directly. It is your responsibility to provide correct insurance information. A copy of the current insurance card is required at first visit. Please notify the clinic immediately if your insurance coverage changes. Clients are requested to check benefits prior to appointment. Co-payments, co-insurance and deductible payments are due at the time of service.

**Outstanding accounts**

When an account is 90 days overdue, we cannot continue to provide additional services, until a payment plan has been arranged with our billing office. At completion of services, payment or initiation of a payment plan is required for any outstanding balance. Checks returned for non-sufficient funds (NSF), closed accounts, or other problems are subject to a $30 service fee and any other charges incurred by Explore Engage Enjoy. Accounts subject to collection activity may be charged a 20% collection fee.

**Sliding Scale Fees**

As a Non-Profit, if there are children that qualify for medically necessary therapy services as determined by licensed and registered occupational, physical, or speech therapists who are unable to afford the services or have no access to insurance these services may be provided at low or reduced cost. A sliding scale will be established based on the primary caregiver's income level. Proof of income as well as proof of denial of access to health insurance will be required prior to accessing reduced cost services. Please inform the office manager if this situation applies to you.

*I have read and received a copy of the Payment Policy for Explore Engage Enjoy. Parents/guardians are responsible for all charges resulting from treatment provided by Explore Engage Enjoy. My signature below indicates that I understand this policy and that I agree to pay amounts due for services received. I have received a copy of the Privacy Practices.*

Services provided for: _____

***(Patient's Name)***

Responsible Party's Signature: _____

Responsible Party's Printed Name: _____ **Date:** _____

**Consent and Authorization to Release and Exchange Information**

Relating to: _____ _____
**(Patient Name)** **(DOB)**

**I hereby authorize this entity: _____**

Entity's relationship to child:_____

To release _____ and/or exchange_____ the following information:
**(Initial)** **(Initial)**

Explore Engage Enjoy and its affiliates, its employees and agents, possess the ability to send electronic communication containing personal health information maintained (such as information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my child's name, address, Member ID number, payment arrangements and balance information).

- I also allow the Explore Engage Enjoy staff members involved in the care of my child to email internally to each other and externally to other professionals involved in the care of the child.
- I understand that the electronic communication will be sent via an unsecure/unencrypted email network.
- I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid for one year from the date listed below.
- I understand that I have a right to revoke this authorization by providing written notice to Explore Engage Enjoy Pediatric Therapy. However, this authorization may not be revoked if Explore Engage Enjoy, its employees or agents have taken action on this authorization prior to receiving my written notice.
- I also understand that I have a right to have a copy of this authorization.
- I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Authorization will remain valid for one year unless otherwise dated here: _____

Please specify any limitations or restrictions on the information disclosed below:

_____

_____

_____ _____
**Signature of Parent/Legal Guardian/Client** **Relationship to Child**

_____ _____
**Print Name of Parent/Legal Guardian/Client** **Date**

**HIPAA Release of Information**
**AUTHORIZATION FORM**

I hereby authorize Explore Engage Enjoy Pediatric Therapy, and its affiliates, its employees and agents, the ability to send me electronic communication containing my or my child's personal health information maintained (such as information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me/my child and which identifies name, address, Member ID number, payment arrangements and balance information) except the following information about me/my child:

_____

[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]

for the purpose of: helping me to resolve claims, health benefit coverage issues, and the purpose of communication regarding plan of care.

- I also allow the Explore Engage Enjoy staff members (including students and volunteers) involved in the care of my child to email internally to each other and externally to other professionals involved in the care of the child.
- I understand that the electronic communication will be sent via an unsecure/unencrypted email network.
- I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid for one year from the date listed below for one year.
- I understand that I have a right to revoke this authorization by providing written notice to Explore Engage Enjoy Pediatric Therapy. However, this authorization may not be revoked if Explore Engage Enjoy Pediatric Therapy, Inc, its employees or agents have taken action on this authorization prior to receiving my written notice.
- I also understand that I have a right to have a copy of this authorization.
- I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

_____ _____

**Signature of Parent/Legal Guardian/Client** **Relationship to Child**

_____ _____

**Print Name of Parent/Legal Guardian/Client** **Date**

# NOTICE OF PRIVACY PRACTICES FOR EXPLORE ENGAGE ENJOY

*Effective Date June 1, 2023*

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

*If you have any questions about this notice, please contact the Office Manager of our office at (541) 900-1418.*

WHO WILL FOLLOW THIS NOTICE. This notice describes our practices and that of (1) any healthcare professional authorized to enter information into your medical record that we maintain at this office; and (2) all employees, staff, and other healthcare personnel.

YOUR MEDICAL INFORMATION. We create a record of the care and services you receive at this office. We need this record to provide you with quality service and to comply with certain legal requirements. This notice applies to all of the records about you maintained by this office. Other therapists or healthcare providers that you use may have different policies or notices regarding the use and disclosure of your medical information. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to (1) make sure that medical information that identifies you is kept private; (2) give you this notice of our legal duties and privacy practices with respect to medical information about you; and (3) follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.The following categories describe different ways that we use and disclose medical information, “Use” is what we do with your information in this office. “Disclose” means sharing your information with others outside this office. All of our permitted uses and disclosures of information fall within one of the categories.

- For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to providers, nurses, technicians, office staff, or other personnel who are involved in your care.
- For Payment. We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party.
- For Health Care Operations. We may use and disclose medical information about you as reasonably necessary. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care.
- To the Department of Health and Human Services (HHS). We must disclose your medical information when requested by HHS when it is undertaking a compliance investigation, review, or enforcement action.
- To You. We must disclose your medical information to you when you request it as described below. We may disclose your medical information to you in other situations.
- Opportunity to Agree or Object. We may disclose your medical information in front of others with your informal permission when you are present. If you are not present or otherwise unable to give permission, we may disclose your medical information to others if, in a healthcare provider's professional judgment, disclosure is determined to be in your best interest. This includes telling family or friends involved in your care about your current medical condition.
- For Appointment Reminders. We may use medical information about you to remind you about appointments using phone calls,
- emails, or text messages. This also allows us to leave appointment reminders and messages with limited information on your voicemail and answering machine.
- Incidental Use. Although we try to limit communications of your medical information to the minimum necessary, we can disclose information that is incidental to an otherwise permissible use.
- Valid Authorization. We may disclose your medical information pursuant to your written authorization. For authorization to be valid, you must sign a form containing certain statements.
- Public Interest and Benefit Activities. We may disclose medical information about you for 12 national priority purposes, including when required by law, such as statute or court order; for public health activities, such as providing immunization records to a school with a parent's permission; to government agencies regarding victims of abuse; to health oversight agencies to carry out legally authorized audits and investigations; pursuant to court orders and subpoenas that meet certain requirements, to law enforcement as described below; to a coroner or medical examiner; as necessary to facilitate organ or tissue donation and transplantation, for research purposes under certain circumstances; to prevent a serious threat to your health and safety or the health and safety of the public or another person; for certain essential government functions, and for workers' compensation or similar programs.
- Law Enforcement. We may disclose your health information if asked to do so by a law enforcement official (1) in response to a

court order, subpoena, warrant, summons, or similar process; (2) about a death we believe may be the result of criminal conduct; (3) about criminal conduct at the office; or (4) in emergency circumstances, in order to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

- Limited Data Set. In certain situations we may disclose your medical information within a limited data set for research, healthcare operations, and public health purposes. A limited data set is medical information about you from which certain identifying information about you, your relatives, household members, and employers has been removed.

DISCLOSURES THAT REQUIRE AUTHORIZATION FROM YOU.

- **Psychotherapy Notes, Marketing, and Sales of Protected Health Information.** Most uses and disclosures of psychotherapy notes, protected health information for marketing purposes, and that constitute a sale of protected health information require authorization.
- **Other.** Other uses and disclosures not described in this notice will be made only with your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU. You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes evaluations and billing records. To inspect and copy medical information that may be used to make decisions about you, you may be required to submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We will select a licensed healthcare professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for this office. To request an amendment, complete and submit an AMENDMENT REQUEST form to the Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the medical information kept by or for the office; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request unless (1) the disclosure is for the purposes of carrying out payment or healthcare operations, and (2) the protected health information pertains to an item or service which you, or another person other than your health insurance, have paid for in full. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit the REQUEST FOR LIMITATION AND RESTRICTION OF PROTECTED HEALTH INFORMATION to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you may complete and submit the PATIENT'S REQUEST TO LIMIT CONFIDENTIAL COMMUNICATIONS to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Privacy Officer.
- **Right to Receive Notice of Breach**. You will receive notification of breaches of your unsecured protected health information unless we determine there is a low probability your PHI was compromised.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office. The summary will contain, in the top right-hand corner the effective date. You are entitled to a copy of the current notice in effect.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact the Privacy Officer. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

**EXPLORE ENGAGE ENJOY**
**RECEIPT OF NOTICE OF PRIVACY PRACTICES**
**WRITTEN ACKNOWLEDGEMENT FORM**

I, _____, have received a copy of Explore Engage Enjoy's Notice of Privacy Practices.

_____ _____
**Signature of Parent/Legal Guardian/Client** **Relationship to Child**

_____ _____
**Print Name of Parent/Legal Guardian/Client** **Date**

**FOR INTERNAL PURPOSES ONLY:**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevents us from obtaining acknowledgment
- ☐ Other (please specify):

_____

_____

## Cancellation Policy

Our clinic's goal is to provide high quality and effective therapy services in a timely manner. Your responsibility in achieving this goal is agreeing to have your child consistently attend their scheduled therapy sessions. Regular attendance and participation are key factors in your child's progression through therapy.

Appointments are in high demand. We require at least 24 hours notice if you MUST cancel your appointment. This may allow us to fill the cancellation with a child who is waiting to get in for treatment. Cancellations must be made by phone. Please note: if you are canceling for a Monday appointment for any reason other than illness you must give us notice on Friday by 2 pm.

**Late Cancel:** Canceling an appointment with less than 24 hours notice.
**No Show:** Not attending an appointment without notifying the clinic.
**No-shows** may result in a **$50 charge** per missed visit to your child's account.

Our therapists are instructed to provide a courtesy call 10 minutes past your set appointment time. If you are 10 minutes late we reserve the request to cancel the appointment and it will be counted as a no show. If you are on your way (i.e. caught behind a train, etc.) it will be at your therapist's discretion if an abbreviated appointment will still be beneficial.

If you late cancel or no show multiple therapy appointments, we reserve the right to move you to a flex schedule. If you have 3 late cancels and/or no-shows within an 8 week period, or 2 consecutive no shows, all future appointments will be canceled. Admin staff will attempt to reach out via telephone as well as having a letter sent to you informing of the switch to flex scheduling and how to proceed. Flex scheduling will allow you to call in and book 1 appointment per discipline 1 week at a time to ensure these times fit your schedule.

Once you have successfully attended 4 consecutive appointments you will have the opportunity to schedule any additional appointments remaining on plan of care. If, while you are on flex schedule, you no show or late cancel an appointment you will be moved to a "same day flex schedule" which allows you to schedule 1 appointment at a time, attending on the same day it is scheduled. You will be responsible for calling to make appointments when on the flex schedule.

Our evaluation time slots do not follow the flex schedule. If you late cancel/no show your evaluation appointment, your child will be rescheduled after all currently scheduled evaluations. If you do provide adequate notice, the evaluation may be rescheduled for the next available opening. If you late cancel or no show 2 initial evaluation appointments, whether with the same discipline or across multiple disciplines, the evaluation will not be rescheduled.

Explore Engage Enjoy understands that things happen in life that are unexpected. While truly sympathetic, frequently missed appointments mean that children are less likely to make progress in a timely manner. In fairness to all clients, this policy is in effect regardless of the reason for the cancellation.

By signing below, I acknowledge that I have read and fully understand Explore Engage Enjoy's cancellation policy.

Signature: _____ Date: _____

**Achieving Therapeutic Success**

We are so excited to be a part of your and your child's development! Achieving success takes effort! By signing this contract you are agreeing that you and your child will follow the treatment plan provided by your therapist. This includes being present in all sessions and participating in your individually designed home exercise program (HEP). Being present in the session means that you will willingly join in and will follow the therapist's instructions. If you have other children we recommend that you make arrangements for childcare so you will be able to be actively involved with the session. If you are unable to make other childcare arrangements, and your other children cannot sit quietly in the session, you may be asked to sit in the waiting room. Your therapist will bring you back to discuss any new additions to the HEP towards the end of the session.

Your Plan of Care will include a set number of visits to promote skill development, educate you on how to best help your child, and develop a HEP with you. You will be advised through the sessions of the progress your child is making. Should your child reach a point in therapy where their progress plateaus* or desired therapeutic outcomes are not achieved resulting from a breach of this agreement; your child will be discharged or take a break from services.

The therapist is responsible for determining if Explore Engage Enjoy is the correct placement for your child's needs. Please understand this determination may not occur in the first session, and may evolve as the therapist learns more about your child.

As the parent/guardian of _____, I agree to follow the following rules:

- I will be at all sessions and if I am not available I will have another caregiver present at the session.
- I understand that sitting in the session provides the best outcome for the HEP.
- There may be times that my full attendance in the session is not required, based on the specific goals of the plan of care. This will be addressed and managed on a case by case tx session.
- If my child is acting out or not cooperating I will help manage my child's behavior.
- I understand other parents and clients may be in the room and I will share space.
- I will ask questions or gain clarification if I do not understand something.
- I will be responsible for helping my child participate in the HEP and bringing the tool kit to each session.
- I will follow school rules regarding illness or infection, and provide as much possible notice if I need to cancel. If I no show for scheduled appointments two times I will be required to make appointments with a flex schedule. My child may also be moved to a flexible schedule if I cancel frequently. Missed appointments are m*y* responsibility to reschedule. I understand availability may be limited.
- Explore Engage Enjoy uses a team approach to therapy and my child may see several therapists over the course of treatment. I understand I may not be notified prior to a change in therapist. I will embrace the change as a chance for my child to practice handling an unexpected event, similar to real life. This will give my child the opportunity to experience adjusting to change in a setting that is equipped to deal with helping children navigate transitions.
- I will be open and honest with my therapist about my child's behaviors, needs, medications, skills, and family dynamics.

I agree _____ Date _____

*A developmental plateau can be an indicator that it is time for your child to practice and integrate the skills they have developed in therapy at home.This should be viewed as a celebration and achievement! Before we reach the point of taking a therapeutic integration “break", you and your therapist will have discussed and developed a plan for continued growth within the home.

**Explore Engage Enjoy Medical History Questionnaire**

Please complete this questionnaire to the best of your knowledge. The more information you can provide the better that we can serve your child

**Primary Concern/Reason for Referral:**_____

_____

**Primary Diagnosis (if any):**_____

**Feeding Concerns (if any):** _____

**Birth/Pregnancy History**

Any problems with the pregnancy? Please explain: _____

_____

During Pregnancy, did mother:

Use tobacco? _____

Use Drugs? _____

Drink Alcohol? _____

Use Medications? _____

Any complications at birth? _____

Type of birth? _____ (Vaginal, C-section, Emergency C-section)

Was baby born full term? _____ How many weeks?_____ Length of NICU stay _____

Birth weight: ___lbs ___oz Birth length: _____ APGAR scores: _____

**Medical Conditions:** _____

Any history of:

Seizures? _____

Vision problems? _____

Hearing problems? _____

Reflux? _____

Breathing problems? _____

Constipation? _____

Broken bones? _____

History of malnutrition? _____

History of family violence? _____

History of abuse? _____

**Allergies (and Reactions):** _____

**Medications/Dosage:**_____

**Immunizations up to date?** _____ Explain_____

**Developmental Milestone Ages:**
Rolling over _____ Sitting up _____ Crawling _____ Walking _____
Saying First Word _____ Toilet trained_____

**Educational Information**
School/Educational program or daycare currently attending_____
Grade level_____
Does your child have an IEP, 504, or Early Intervention Services? _____
If **Yes, what** are the services for? _____

**Does your child's teacher or daycare provider have concerns about your child's development?**_____

**Surgeries (and Dates):**_____

**Speech and Language**
Does your child struggle with any of the following?
Understanding what you are saying _____
Following simple directions ("shut the door" or "get your shoes")_____
Answering questions correctly (who/what/where/when/why questions)_____
Using speech to communicate (1-2 words / 3-4 words / Complete Sentences)_____
Using gestures to communicate_____
How much of your child's speech do you and others understand? _____
_____

**Has your child received therapy services before?** _____ Explain_____
_____

**Please describe your child's strengths** _____
_____

**What do you want us to know about your child that you are not comfortable talking about in front of your child during the evaluation?** _____

_____

## Speech Therapy Outcome Assessment

Please fill these out to the best of your ability in order to assist us with understanding your child's needs. We will send a similar assessment via email at 6 months (unless discharged sooner) and upon completion of treatment (discharge) in order to track outcomes.

For any of the areas if they do not apply to your child please select N/A (Not Applicable).

- For example: some clients may be focused primarily on swallowing while others are working on saying their first word and others are focused on articulation while working with our therapists.

Please respond to the following questions using this 1-5 rating scale:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| **Never** | **Sometimes** | **Half the Time** | **Most of the Time** | **Always** |

| **Speech and Fluency** | | | | | | |
|---|---|---|---|---|---|---|
| Activity | 1 Never | 2 Some Times | 3 Half the Time | 4 Most of the Time | 5 Always | N/A Not Applicable |
| **My child struggles with:** | | | | | | |
| Stuttering | | | | | | |
| Voice (pitch, loudness) | | | | | | |
| Articulation (clearly speaking) | | | | | | |
| **Language** | | | | | | |
| Activity | 1 Never | 2 Some Times | 3 Half the Time | 4 Most of the Time | 5 Always | N/A Not Applicable |
| **My child struggles with:** | | | | | | |
| Receptive language (understanding what is said) | | | | | | |
| Expressive language (using language to express self) | | | | | | |
| Prelinguistic and paralinguistic skills (joint attention, signaling, gestures, signs, and body language) | | | | | | |
| Access to Augmentative and Alternative Communication (AAC) | | | | | | |
| **Social Communication** | | | | | | |

| Activity | 1 Never | 2 Some Times | 3 Half the Time | 4 Most of the Time | 5 Always | N/A Not Applicable |
|---|---|---|---|---|---|---|
| **My child struggles with:** | | | | | | |
| Social pragmatics (language use based on social aspects of situations) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Cognition** | | | | | | |
| Activity | 1 Never | 2 Some Times | 3 Half the Time | 4 Most of the Time | 5 Always | N/A Not Applicable |
| **My child struggles with:** | | | | | | |
| Attention | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Memory | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Problem solving | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Swallowing** | | | | | | |
| Activity | 1 Never | 2 Some Times | 3 Half the Time | 4 Most of the Time | 5 Always | N/A Not Applicable |
| **My child struggles with:** | | | | | | |
| Swallowing or eating safely | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Initial Intake Satisfaction**

| Satisfaction Questions: | 1 Strongly Disagree | 2 Disagree | 3 Neutral | 4 Agree | 5 Strongly Agree |
|---|---|---|---|---|---|
| Intake Process | | | | | |
| The intake process was clear and easy to understand. | ☐ | ☐ | ☐ | ☐ | ☐ |
| After I was referred, I was able to access therapy services in a reasonable time. | ☐ | ☐ | ☐ | ☐ | ☐ |
| I clearly understand my insurance benefits and financial responsibility. | ☐ | ☐ | ☐ | ☐ | ☐ |

Explore · Engage · Enjoy

Pediatric Therapy

## WHO WE ARE

Welcome to Explore Engage Enjoy! No matter where you and your child are on your journey we appreciate you trusting us to be a part of it. We look forward to moving forward together!

### Overview

Explore Engage Enjoy is a nonprofit organization established for public benefit for charitable, educational, and scientific purposes under section 501(c)(3) of the Internal Revenue Code. It is a pediatric outpatient therapy clinic offering occupational and speech therapy services for children from birth to age 18 years old. We are currently hiring for all therapy positions ***but do not have a physical therapist employed yet so these services are currently on hold.***

### Mission Statement

It is the mission and paramount purpose of Explore Engage Enjoy to improve pediatric therapy outcomes through research, rural access to care, and treatment for speech, occupational, and physical therapy.

### Purpose Statement

Explore Engage Enjoy is organized and operated to provide therapy services and opportunities for clinical research in the areas of occupational, physical, and speech therapy in order to allow the quality of outcomes to direct best practice decisions. Children with disabilities in rural areas often have less access to high quality therapy services that they need to develop and thrive in their homes, schools, and communities. Explore Engage Enjoy focuses on improving therapy access and quality in rural areas through direct therapy services, patient centered outcomes research, therapy student education, and program development.

**Pediatric Therapy Services**

Explore Engage Enjoy provides high quality pediatric occupational therapy, physical therapy, and speech therapy services to children from birth to age 18 years with disabilities in rural areas regardless of payor source. We strive for the highest quality of service using evidenced based practice with a heavy emphasis on parent education and individualized instruction to engage families to enjoy their relationships with their children. Treatment sessions will focus on reaching those goals through direct service, caregiver training, and home exercise instruction. Frequent monitoring of progress in collaboration with parents is best practice and will be implemented throughout sessions in order to help children and families meet their goals.

**Pediatric Therapy Research**

Explore Engage Enjoy participates in advancing pediatric occupational therapy, physical therapy, and speech therapy professions through clinical research to inform best practice guidelines. Clinical research allows for professionals to recognize areas of need and explore treatment methods that can meet these needs to provide the highest quality of outcomes as measured by qualitative and quantitative methods. Any new research as well as current literature will be used to inform therapy service and shape best practice guidelines. Explore Engage Enjoy supports and encourages therapists to pursue research in their areas of interest and specialty areas and will assist with new projects that are supportive of the mission.

**Therapy Student Training**

Explore Engage Enjoy allows occupational therapy students to complete fieldwork, physical therapy students to complete practicums, and speech therapy students to complete clinical rotations so they can learn how to implement research into their future practice as well as provide the highest quality of care using evidenced based methods in the future. Students will take what they have learned back to universities as well as their future communities to further spread knowledge and improve therapy quality. Working in conjunction with therapy education programs Explore Engage Enjoy will provide opportunities for students to complete scholarly projects or dissertation rotations as is appropriate and useful in fulfilling the mission.

**Future Growth**

Explore Engage Enjoy is open to growth as the needs of the community and the children we serve change. Ideas for growth may come from any employee or community member and may be implemented with collaboration of staff, community, and the board of directors. Based on financial stability, staffing, and community support individual projects and areas growth will be considered and implemented as able.