Pediatric Therapy Services
Office: 803.329.9500 | Fax: 803.228.0101

To: Therapy World Family

First and foremost, we would like to thank you for trusting Therapy World in providing therapy services to your child and family. It is an honor to work with you and the plan of care team to ensure your child's developmental growth and success in everyday activities.

On the day of your first session, your therapist will be conducting an evaluation to determine your child's functional skills, so collaboratively the therapist and family can define what are the priorities, concerns, and goals for therapy. The evaluation time ranges from 45-75 minutes. The therapist will initially discuss the child's medical and developmental history with the family. Also, you might be asked questions on how your child responds to daily social interactions, sensory information, and their performance in activities of daily living such as dressing, eating, and bathing. Then, the therapist will engage with your child in a formal assessment and/or informal clinical observation. The therapist will observe your child's social skills, expressive and receptive language skills, visual motor and/or visual perceptual skills, motor skills including gross motor and fine motor skills and sensory processing skills. The therapists will generate the evaluation findings using standardized assessments, clinical observations, clinical questionnaires, and family report. Since your therapist only has a short amount of time to interact with your child, we have some suggestions that may support your child and therapist performance during the assessment:

1. Let your child know someone friendly will be playing with them.
2. Avoid any distractions such as tablets, TV, or electronics before and during evaluation.
3. Provide a good meal (unless participating in a feeding evaluation and indicated by therapist) and sleeping routine before session.
4. If the evaluation is in the home, have a testing area ready for the evaluation.
5. If the evaluation is in the home, have available age appropriate and favorite toys in the testing area.

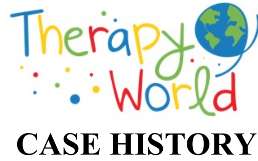
Your therapist may ask you to show them your child's favorite toys, playing area, and routines. This will allow your therapist to learn more about your child and help build a rapport. Once the therapist has completed the formal assessment, the therapist will discuss the preliminary evaluation findings with you at the end of the evaluation and will discuss their recommendations for areas for improvement, specialized treatment, and therapy session duration and frequency. If treatment is not recommended, the evaluating therapist will discuss other resources, options, and recommendations. You should receive a written report within 3 weeks. We encourage you to set up your therapy account by visiting our Patient Portal at Fusion Web Clinic to access the evaluation report. If you do not have an account, please ask our administration team for further instructions in setting up your account.

Lastly, please remember to have the following items ready prior to the evaluation:

1. Intake-forms filled out.
2. A current photo ID (license).
3. Insurance and social security card.
4. Referral, if needed.
5. School reports, including goals for school-based therapies, if applicable.
6. Prior evaluations, if applicable.
7. Name/addresses of individuals you might want the report sent to.
8. Current list of medications. If your child is on medication and regularly takes it prior to the evaluation, please ensure this happens the day of the evaluation.
9. Bring any equipment that your child regularly uses such as eyeglasses, braces and splints etc.
10. Guardian papers (if joint, or sole custody)
11. A list of questions to ask the therapist.

If you have any further questions and/or concerns regarding your child's initial evaluation, please feel free to contact your therapist or our office at (803) 329-9500.

Thank you from the Therapy World Team!



CASE HISTORY

PERSONAL INFORMATION

Child Name:	Gender: Male Female	DOB:	Age:
Address: (Street, City, State, Zip Code)		Diagnosis/Problem:	
Parent/Caregiver Name(s):		Relationship to Patient:	

Home Phone #:	Cell Phone #:	Work Phone #:	E-Mail Address:
Emergency Contact: (Different From Above)			Relationship to Patient:
Home Phone #:	Cell Phone #:	Work Phone #:	E-Mail Address:

PREGNANCY & DELIVERY HISTORY

QUESTION	ANSWER	DETAILS
Was prenatal care received?		If YES, what month was it initiated?
Were there medical concerns prior to/during pregnancy?		If YES, please explain in detail:
Were there emotional concerns prior to/during pregnancy?		If YES, please explain in detail:
Did you have a premature pregnancy (less than 37 weeks)?		If YES, at how many weeks was the child born?
Did you have any complications at birth?		If YES, please explain in detail:
Were any of the following present at birth: Jaundice, breathing difficulties, feeding difficulties, NICU?		If YES, please write which ones:
Is your child adopted?		If YES, when was s/he adopted? If YES, where is s/he adopted from?
Do you know any birth history or orphanage details?		If YES, please explain:
Does your child know he/she is adopted?		

Please describe IN DETAIL the labor and birth of your child (weight, form of delivery, complications, postnatal care):

DEVELOPMENTAL HISTORY

Please indicate at what age your child began:

SKILL	**AGE**	**DETAILS**
• Breast Feed		
• Bottle Feed		
• Roll Over		
• Recognize familiar faces/voices		
• Reach for toy		
• Crawl		
• Sitting		
• Pull to Stand		
• Walk		
• Isolate fingers to count and/or point		
• Drink from a straw		
• Eat finger foods		
• Uses a spoon/fork		
• Drinks from an open cup		
• Babbles		
• Say first words		
• Pair two words		
• How many words total:		

SURGICAL HISTORY

Please list all surgeries and hospitalizations your child has had and/or will have:

Surgeries/Hospitalizations:	**Date:**	**MD/Surgeon:**	**Condition/Details:**

MEDICAL HISTORY

Does your child have any current/past Medical History? If Yes, Please check "√" all that apply. I acknowledge

□ Acid Reflux	□ Cerebral Palsy	□ HIV/AIDS	□ Swallowing Problems
□ ADD/ADHD	□ Cyanosis	□ Jaundice	□ Torticollis
□ Anoxia	□ Cytomegalovirus	□ Juvenile Arthritis	□ Traumatic Brain Injury
□ Allergies:_______________	□ Down Syndrome	□ Plagiocephaly	□ Visual Problems
□ Asthma	□ Ear Infections/Tubes	□ Pneumonia	□ Other:
□ Autism/PDD	□ Headaches	□ Prematurity	□ Other:
□ Balance Problems	□ Heart Problems	□ Seizure/Epilepsy	□ Other:
□ Cancer	□ Hepatitis	□ Speech/Lang Problems	

Is there any of the above medical history in the immediate family? □ Yes □ No
If yes, explain:

Has your child seen any of the following specialist(s):
□ Cardiologist □ Neurologist □ Orthopedist □ Optometrist/Ophthalmologist
□ Psychologist/Psychiatrist □ Developmental Pediatrician

MEDICATION HISTORY

Please list current medications, dosage and the condition the medication is treating:

Medication	**Dosage**	**Condition**

INTERVENTION HISTORY

Please list the names of any specialists that have evaluated your child, date of the evaluation & any diagnoses:

Specialist Name	**Date of Evaluation**	**Diagnoses**

HEARING/AUDIOLOGY HISTORY

Has your child every received a hearing screen or a formal evaluation to test their hearing? **YES** **NO**

When:	**Date:**	**Results:** Passed Failed

FAMILY/SOCIAL HISTORY

Please list the names, ages and relation of those living in your home:

Name	**Age**	**Relationship to child**

My child's primary caregiver is:

What kind, if any, outside play area does your child have access to:

Does your child have his/her own bedroom or share?

My child's sleeping habits: (location & hours)

Is your child a picky eater? If yes, please explain (ie. aversions to textures and/or smells):

Describe any significant changes your child has experienced in the past 3 months:

Are there any religious, spiritual, or ethnic customs your therapist should be aware of? Please describe:

My child's strengths are:

Please describe your child's play skills:

SELF CARE SKILLS

Please circle the "%" level that indicates the level of independence your child demonstrates with the following skills.

Skill	
• Brushing teeth	
• Bathing	
• Dressing	
• Toileting	
• Self feeds	
• Use of utensils	
• Sippy cup	
• Open cup	
• Straw drinking	
• Sits for meals	
• Organizes homework	
• Answers basic questions about self (name & age)	
• Recognizes printed name	
• Asks for help	

SCHOOL/DAY CARE HISTORY

Name of my child's current School/Day Care:

My child's current grade/placement:

My child's current Teacher(s) Name(s):

Do I have permission to contact your child's school teacher/therapists? **YES** **NO**
If yes, please provide their phone number and /or email address:

My child's current School Therapist(s) Name(s):

My child receives the following support services (ie. Physical, occupational, speech therapy) at school:

My concerns surrounding my child:

What other information can you tell me about your child?
What questions do you have regarding therapy and your child?
What do you hope we can accomplish in therapy?

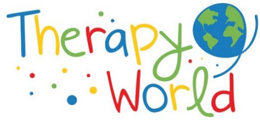
Thank you for your assistance in completing this form. This information is confidential and will be used strictly for therapeutic purposes.

____ ____

Name of person completing this form Relationship to the child

____ ____

Signature of person completing this form Date



Attendance Policy

Cancellation/Missed Visit Policy:

- Please call our clinic at (803) 329-9500 and/or your therapist within **24 hours** in advance or as soon as possible if you need to cancel your appointment.
- If you miss your appointment, please call our clinic and/or your therapist for possible rescheduling.
- Please talk to our clinic admin and/or therapist regarding scheduling/attendance concerns (such as transportation issues).
- Your child will be **placed on hold** from therapy for the following reasons:
    1. Your child misses **3 or more** scheduled therapy sessions within a **30-day** period and have not re-scheduled at least 2 sessions.
    2. Your child has **2** no call/no show missed appointments within a month.
    3. Your child is more than 10 minutes late for **3 visits** within a **30-day** period.

***If any of the above occurs, your child will be placed on hold until another time becomes available.*

After the first no call/no show visit, the therapist will attempt to call you. If you do not return the call **within 3 business days** to confirm your next visit, your child will be placed on hold until another time becomes available.

Parent/Guardian Supervision Policy:

Our liability insurance requires that any child under the age of 18 **MUST** always have a parent or guardian on premises during therapy sessions.

Illnesses/Sickness:

In consideration of other children and your therapist, **please do not bring your child to therapy or accept therapy services if they have any of the following:**

- Fever of 100 degrees or higher within the last 24 hours
- Vomiting
- Diarrhea
- Head Lice
- Other infectious illnesses (i.e., Strep throat, pink eye, RSV, MRSA, Chicken Pox, COVID 19, etc.)
- At least 24 hours after your child has started an antibiotic from the doctor

If you are unsure if you should bring your child to therapy or receive services, please call your therapist.

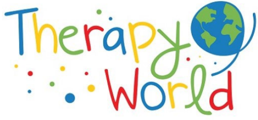
Inclement Weather Policy:

In the event of inclement weather, please check your local weather channel or our website for closure details.

Thank you for reviewing and accepting our attendance/cancellation/no-show policy. We look forward to working with you and your child!

____________________________________ ____________________________________

Parent/Guardian Signature Date



Cancellation Charges Policy:

If you fail to keep your scheduled appointment, or do not cancel within 24 hours of your appointment time you will be charged a $50.00 fee on the day of your cancelled or no-show appointment. This will NOT be billed to your insurance and will be YOUR financial responsibility.

Credit Card Charge Authorization

Credit Card Type: ☐ American Express ☐ VISA ☐ Discover ☐ Master Card

Cardholder Name: ____

Credit Card Number: ____

Expiration Date: ____

CVV2 (Security Code): ____

Cardholder ZIP Code: ____

By signing below, I authorize Therapy World to charge my credit card for the amount described above. I future acknowledge that I have been informed of the cancellation and no-show policies of Therapy World and agree to the terms and conditions. I waive my right to dispute these charges. I understand that Therapy World will save my credit card information into their secured system, and it will be filed appropriately for future transactions.

Thank you for reviewing and accepting our attendance/cancellation/no-show policy. We look forward to working with you and your child!

_____________________________________ _____________________________________

Parent/Guardian Signature Date

Pediatric Therapy Services

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New Patient Data Form

Patient's Name (First, Middle, Last): ____
Mailing Address: ____
City, State, Zip Code: ____
Home Phone: (____) ______-______ Cell Phone: (____) ______-______ Work Phone: (____) ______-_______
Email: _______________________________ Patient's Date of Birth: ____________________ Age: __________
Parent(s) Social Security Number: __________________________________
Referring MD: ____ Date of Injury/Diagnosis: ________________
Have you been a patient of Therapy World, LLC before: □ Yes □No
If yes, when? ____
Emergency Contact Name: ____________________ Relationship: ____________ Phone: (____) _____-______

Primary Insurance

Name: ___________________ ID #: _____________ Group #: __________ Insured SS #: _____-_____-_______
Insured: ___________________ Relationship to Insured: _________________ Insured DOB: ____/____/____

Secondary Insurance

Name: ___________________ ID #: _____________ Group #: __________ Insured SS #: _____-_____-_______
Insured: ___________________ Relationship to Insured: _________________ Insured DOB: ____/____/____

Authorization

Authorization to treat: I hereby authorize *Therapy World, LLC* to provide treatment as prescribed by my physician and therapist.
Authorization to obtain/release information: I hereby authorize *Therapy World, LLC* to obtain or release information to my physician and/or insurance company as needed during the course of my treatment.
Assignment of benefits: I hereby authorize my insurance company to make payment directly to *Therapy World, LLC* for services rendered. I accept all responsibility for treatment costs not covered or reimbursed by my insurance company.

Therapy World, LLC **Patient Acknowledgment and Consent • Financial Policy**

____
Print Name of Patient

In signing below, you are acknowledging receipt of the *Therapy World, LLC* financial policy. You hereby agree to the terms listed within and understand that any charges incurred that are not paid by your insurance carrier will be the patient's responsibility. Payment options are available to patients but must be authorized by the Billing Department.

_____________________________________ _________________________ _______________________
Signature Date Witness

____
Relationship to Patient

Pediatric Therapy Services

Office: 803.329.9500|Fax: 803.228.0101

HIPAA Compliance

CONSENT TO DISCUSS WITH FAMILY MEMBER(S) AND/OR PERSONAL REPRESENTATIVE AUTHORIZATION FOR TREATMENT AND/OR FINANCIAL INFORMATION IN THE PATIENT'S ABSENCE.

I hereby give my permission for *Therapy World, LLC* therapist and other staff, including clerical, to disclose and discuss my medical and financial information with the following individual(s):
Name: ______________________________________ Relationship to Patient: ____________________________
Name: ______________________________________ Relationship to Patient: ____________________________

Patient/Guarantor Signature: _______________________________ Date: _______________________________
Witness Signature: ____ Date: _______________________________

I, _________________________________ give permission for *Therapy World, LLC* to disclose protected Health Information in the form of:

Please mark all that apply:
□ May Leave DETAILED messages via answering machine, email, or letter.
□ In person with myself and authorized individual(s) as indicated above.

I have been provided a copy of *Therapy World, LLC* Notice of Privacy Practices, version effective January 10, 2018. I consent to the uses and disclosures of my protected health information as outlined in the Notice of Privacy Practices.

____ ______________________
Signature of Patient or Guardian Date

____
Print Name of Patient

____
Print Name of Guardian (if applicable)

Pediatric Therapy Services
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HIPAA Communication Compliance

CONSENT TO DISCUSS WITH PERSONAL REPRESENTATIVE AUTHORIZATION FOR TREATMENT AND/OR FINANCIAL INFORMATION IN THE PATIENT'S OR GUARDIANS' ABSENCE.

Patient's Name: ____ Date of Birth: _______________________
Parent and Guardian Name: ____
Current Address: ____

☐ **Information to be released** — *goals/objectives, progress, observations, interventions, recommendations.*
I HEREBY give permission for *Therapy World, LLC* therapist and other staff, including clerical, to communicate using electronic mail or phone with the following individuals regarding my child:

Primary Care Physician
Facility Name: _____________________ Primary Contact Name: _________________ Title: ____________
Phone Number: _____________________________ Email: _______________________________________

School District/Teacher
School Name: _____________________ Primary Contact Name: _________________ Title: ____________
Phone Number: _____________________________ Email: _______________________________________

Specialized Services
Facility Name: _____________________ Primary Contact Name: _________________ Title: ____________
Phone Number: _____________________________ Email: _______________________________________

Facility Name: _____________________ Primary Contact Name: _________________ Title: ____________
Phone Number: _____________________________ Email: _______________________________________

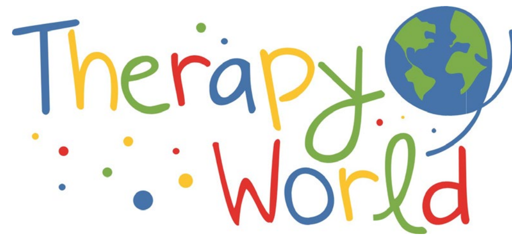
Facility Name: _____________________ Primary Contact Name: _________________ Title: ____________
Phone Number: _____________________________ Email: _______________________________________

I understand that this authorization takes effect the day that I sign it. I also understand that I may change this authorization at any time.

____
Print Name of Patient

____
Print Name of Guardian (if applicable)

______________________________________ ____________________
Signature of Patient or Guardian Date



CONSENT TO VIDEO-TAPE and/or PHOTOGRAPH THERAPY SESSIONS

Dear Parent(s),

For training and supervisory purposes, it is often very helpful to video-tape therapy sessions with our children.

However, privacy and discretion are of supreme importance in this industry (and to us), so we require written consent from parent(s) before any sessions can be video-taped or photographed.

Videos are viewed only by your child's therapists, the therapists' immediate supervisors, and/or students. Videos are used to provide guidance and instruction from the supervisors to the therapists and students.

We would also like to use some photographs for display in the office, office advertising, and social media outreach (i.e., Facebook, Instagram, and our own website).

Please choose one of the following consent statements below:

☐ I give permission for my child's therapy sessions to be video-taped and/or photograph for training, supervisory, advertising, and social media outreach purposes. I understand that my consent is voluntary and may be revoked by me at any time given written notice via email to support@mytherapyworld.com.

☐ I give permission for my child's therapy sessions to be video-taped and/or photograph for training and supervisory purposes only. I understand that my consent is voluntary and may be revoked by me at any time given written notice via email to support@mytherapyworld.com.

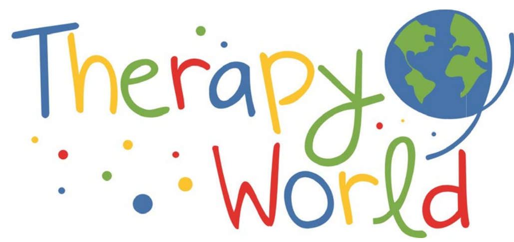
☐ I opt out of any videotaping or photography during my child's sessions. I understand that my consent is voluntary and may be changed at any time given written notice via email to support@mytherapyworld.com.

Child's Name: _____________________________________ Date of birth: ________________________

Therapist: ____

Parent/Guardian (printed): ___________________________

Signature: ____ Date: _______________________________



CONSENT TO RECEIVE TEXT MESSAGES

1. By signing below, I authorize Therapy World and its staff to contact me by SMS (Short Message Service) text message for appointment reminders.
    a. I understand that message/data rates may apply to messages sent by Therapy World under my cell plan.

2. I understand that the information included in text messages may include child's first name, date/time off appointments, name of EISC (Early Intervention Service Coordinator/other service provider) and EISC/provider phone number, or other pertinent information.

3. I understand that text messaging is not a secure format of communication. There is some risk that personally identifiable information, protected health information, and/or other sensitive or confidential information contained in such text may be misdirected, disclosed to, or intercepted by unauthorized third parties.

4. I know that I am under no obligation to authorize Therapy World and its staff to send me text messages. I may opt of receiving these communications at any time given written notice by emailing support@mytherapyworld.com.

5. My text/mobile phone number is: ______________________________ and/or you may use the number that is on file.

6. By signing below, I indicate I am the primary user for the mobile phone number listed above. I accept the risk explained above, and consent to receive text messages from Therapy World and its staff to the phone number that I have provided.

Child's Name: ____ Date of Birth: ______________________

Therapist Name: ____

Parent/Guardian Name (printed): ____

Parent/Guardian Signature: ____ Date: _______________

How to Use the New Patient Portal

Did you know your clinic has a new patient portal? The patient portal is a secure way to view your child's important therapy information and make payments, anytime and anywhere.

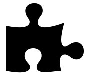
Benefits

Appointments

You no longer need to call the clinic to check when your next appointment is. All upcoming appointments can be viewed on the portal.

Documentation

If you need a copy of your child's evaluation for their doctor, you can quickly print or download it from the portal.



Home Activities

Misplaced that activity handout? No worries! View and print it from the portal.

Account Balance & Invoices

Keep track of your invoices and account balance in one place.

Make a Payment

Conveniently pay your bills online and print a receipt. You can even save your card on file for quicker payments next time!

Accessing the Portal

1. Type the following web address into your browser.

   login.fusionwebclinic.com/portal/mytherapyworld

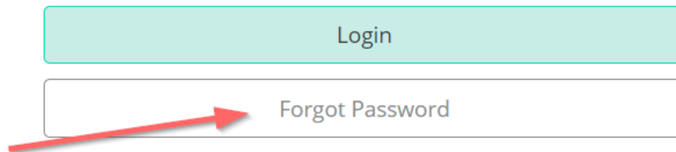
   Tip: Bookmark the web page so you can access it quickly next time you need to login!

2. Login by entering your email address and the password that you created when your account was set-up.

Resetting Your Password

If you forgot your password, there are two ways you can reset it.

- Click the *Forgot Password* button on the login page. You will receive an email to create a new password. The link will expire after 2 hours.



- Reach out to your clinic! Your clinic can also email you a link to reset your password. Any link emailed by clinic will expire after 24 hours. However, if you click an expired link you will still be directed to the login page where you can click the *Forgot Password* button.

Additional Help with the Portal

For more information about how to use the portal, in the upper right click the **Help** icon.