STONE OAK THERAPY SERVICES & LEARNING INSTITUTE

1020 Central Parkway South, San Antonio, TX 78232 Phone (210) 798-CARE (2273) Fax (210) 495-1479
Email address stoneoaktherapy@gmail.com **Website** www.stoneoaktherapy.com

STONE OAK THERAPY SERVICES & LEARNING INSTITUTE
Patient & Insurance Information Sheet

Dear Parent,

We are pleased that you are considering our center for your child's services. In order to provide the best care possible and to expedite scheduling your child's initial appointment with us, please use this check list to track the documents you need to sign and return to us.

- ❑ Patient-Parent Handbook
- ❑ Patient & Insurance Information
- ❑ Consent for Release of Information
- ❑ Terms of Service and Payment Agreement (Insured Pay & Private Pay)
- ❑ Signature to verify Receipt of HIPAA Privacy Notice, Our Privacy Practices
- ❑ Medical-Social History
- ❑ Additional information such as reports from consultations or assessments provided by physicians, therapists and school district
- ❑ Release and Waiver of Liability Assumption of Risk and Indemnity Agreement

PATIENT INFORMATION

PATIENT NAME:	DOB:
SSN:	MALE FEMALE
ADDRESS: CITY AND ZIP	HOME PHONE: ( ) -
EMAIL ADDRESS:	WORK PHONE: ( ) -
PARENT OR GUARDIAN:	ALTERNATE PHONE: ( ) -
EMERGENCY CONTACT:	EMERGENCY CONTACT PHONE:
RELATIONSHIP TO PATIENT:	( ) -
INSURANCE INFORMATION	
PRIMARY INSURANCE:	POLICY NUMBER:
POLICY HOLDER:	GROUP NUMBER:
INSURANCE PHONE NUMBER:	SSN:
POLICY HOLDER D.O.B.	RELATIONSHIP:
EMPLOYER NAME:	EMPLOYER PHONE:
SECONDARY INSURANCE:	POLICY NUMBER:
POLICY HOLDER:	GROUP NUMBER:
INSURANCE PHONE NUMBER:	SSN:
POLICY HOLDER D.O.B.	RELATIONSHIP:
EMPLOYER NAME:	EMPLOYER PHONE:
PRIMARY CARE PHYSICIAN INFORMATION	
NAME OF PRIMARY CARE PHYSICIAN:	OFFICE PHONE: ( ) -
ADDRESS:	OFFICE FAX: ( ) -

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CONSENT TO TREATMENT AND RELEASE OF INFORMATION

I authorize the staff of Stone Oak Therapy Services to:

1. Administer and perform those treatments that have been prescribed by my or by my child's physician.
2. Release pertinent medical information to my/my child's physician, referring agency, or insurer and others as may be required.
3. Request and obtain medical information from my/my child's physician and other health care professionals as necessary to provide quality therapy services.

Printed Name of Patient

Printed Name of Responsible Party **Relationship to Patient**

Signature of Responsible Party **Date**

Terms of Service and Payment Agreement

INSURED PATIENT:

I authorize Stone Oak Therapy Services to submit claims for services rendered to my insurance carrier or third party payer, and I request payment for these services be made directly to Stone Oak Therapy Services or its designee.

I understand that some services may not be covered by my insurance plan, or may be reimbursed at a much lower rate than what is usual and customary for this area. I further understand that I am responsible for any and all charges for services rendered that are not paid by my insurance carrier. This includes any fees incurred by Stone Oak Therapy Services in the event that my account must be forwarded to a collection agency due to non-payment.

ALL REQUIRED PAYMENTS ARE DUE AT THE TIME OF SERVICE.

Full payment at the time of service will be required. If Stone Oak Therapy Services is unable to bill my carrier directly, an invoice will be provided for me to submit to my carrier for reimbursement.

PRIVATE PAY PATIENT:

I accept responsibility for any and all charges for services provided to me/my child by Stone Oak Therapy Services. This includes any fees incurred by Stone Oak Therapy Services in the event that my account must be forwarded to a collection agency due to non-payment.

Full payment is due at the time of service/as indicated on statements sent to me by Stone Oak Therapy Services. My account will be considered delinquent if payment is not received within ten days of the payment due date listed on my statement. I understand that therapy services may be discontinued if my account becomes delinquent.

Parent Signature **Date**

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the Stone Oak Therapy Services and Learning Institute's ***NOTICE OF PRIVACY PRACTICES***, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal or my child's personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Parent or Guardian of Patient Date Relationship to Patient
Printed Name:____________________________ ____________________________

IF PARENT OR GUARDIAN OF PATIENT REFUSES TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW.
( ) Parent or Guardian of Patient refused to sign this Acknowledgement.
Print Name________________________Date____________
Employee Printed Name and Signature:
____

RELEASE AND WAIVER OF LIABILITY ASSUMPTION OF RISK AND INDEMNITY AGREEMENT

In consideration of me or my child receiving services at Stone Oak Therapy Services and Learning Institute, the undersigned (representing all parties affiliated with the patient and/or student), in full recognition and appreciation of the dangers and risks inherent in such therapeutic activities associated with helping children with cognitive and/or physically disabilities, do hereby waive, release, and forever discharge Stone Oak Therapy Services and Learning Institute, its parent and affiliate organizations, its officers, agents and employees from and against all claims, demands, action or causes of action for costs, expenses or damages to personal property or personal injury, or death which may result from such participation in these activities.
The undersigned also acknowledges that injuries received may be compounded or increased by negligent rescue operations or procedures. This waiver of liability extends to any rescue operations performed by the staff on the premises or on route to an emergency medical facility.
The undersigned affirms that all health information pertaining to the patient and/or student has been divulged prior to services being rendered. The undersigned acknowledges that s/he retains general medical/health insurance to cover any such accidents in the event they do occur.
This waiver is intended to be as broad and inclusive as is permitted by law and that if any portion is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.
I have read this release and waiver of liability, assumption or risk and indemnity agreement, fully understand its terms, understand that I have given up substantial rights by signing it, and have signed it freely and voluntarily without any inducement, assurance, or guarantee being made to me and intend my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

____________________________ ____________________________
Patient or Student's Name Parent's Name Date

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MEDICAL & SOCIAL HISTORY
(PRESCHOOL 3 YR TO 5 YEARS)

Child's Name:________________________________DOB:_________

HEALTH SCREENING & EARLY DEVELOPMENT

Developmental milestones: Please describe the age at which your child mastered the following activities: Use Months or years. Cooing: ______ Babbling _____ First words ________ Two-Word Combinations (i.e. mommy bye-bye, milk gone) ___ Simple Sentences (i.e. I want to play outside), _____ Complex Sentences (i.e. "she said she didn't want to play anymore because I wouldn't let her have my Barbie") _________ Speech that is between 75% to 90% clear to an unfamiliar listener _________ Assemble 3 piece puzzle :________ 12 piece puzzle ________ 24 piece puzzle __________ Give complete answers that make sense to open ended questions asked such as "why do kids need to brush their teeth? " _________ Participate in a group activity without redirection (finger plays, singing in circle time, arts & craft), _______ Follow simple directions ("go get your shoes")_________ Follow complex directions ("go get the dictionary which is on the second shelf of the bookcase in the den)_________ Rolling over: _________ sitting alone _________ Crawling _______ Pulling up to stand __________ Walking __________ Running_____________ Throwing overhand ___________ Picking up small objects with hands (cheerios, raisins) __________ Pass toys from one hand to another or play with a toy using both hands_______ Scribbling with a crayon _______________ Writing letters ______________ Toilet training_____________ Drink from an open cup with minimum spillage _________ Hold a spoon/ fork to self feed with minimum mess_________ feed himself/herself ____________ Brush teeth alone _______ use the potty alone ______ get dressed by himself __________

Has your child had problems with any of the following? (Yes or No) If yes, please explain.

Vision (wears glasses, etc.)____

Hearing (hearing aides, etc.)____

What is the date of most recent Vision and Hearing Screening? _________Vision __________Hearing

If your Child has never had a formal Vision and Hearing Test, would you or your physician attest to your child's vision and hearing skills to be functional and adequate for developmental testing (Speech, PT, OT, etc.)?_____________________

Are there any concerns regarding:

Speech ____

Coordination (running, throwing, writing, etc.) ____

Serious illnesses (Complications with childhood illnesses, high fever, etc.)__________________________

____

Has your child participated in an Early Childhood Intervention Program? ____ If yes, please describe services received, provider, and length of service:____

____

____

MEDICAL HISTORY

Are immunizations up to date? _____ If not, what immunizations are missing? ______________________

Does your child receive annual flu vaccines? _____ List dates received: __________________________

Hospitalizations (accidents, etc.)____

____

Surgeries:____

____

Current Medications (type, purpose):____

____

Date of most recent physical:_________________________Physician:___________________________

Check the appropriate items that apply to your child's' health condition(s) and childhood illnesses.

__Allergies	__Heart trouble	__Vision problems
__Asthma	__Joint pains	__Chicken pox
__Chest pains	__Reaction to drugs	__Diphtheria
__Colds (frequent/severe)	__Skin rashes or eczema	__Measles
__Convulsions or seizures	__Stomach disorder or abdominal pain	__Mumps
__Ear trouble	__Tumor or growth	__Pneumonia
__Frequent sore throats	__ Urinary infection	__ Rheumatic Fever
__Headaches (frequent)	__ Minor/Major Head Injury	

__Other:____

____

Please explain any areas checked above:____

____

Diagnosis (describe each and when diagnosed):____

____

____

____

____

____

CURRENT THERAPY SERVICES (PT, OT, ST, Behavioral Support, at school or in the community): List Current Outpatient Therapists as follows:					
Services	Date Initiated	Length of Service	Name of Provider	Address/Phone	Frequency

PREVIOUS THERAPY SERVICES (PT, OT, ST, Behavioral Support at school or in the community): List Previous Outpatient Therapists as follows:					
Services	Date Initiated	Length of Service	Name of Provider	Address/Phone	Frequency

EVALUATIONS OR TESTS PERFORMED (ST, OT, PT, Neurological, MRI, X-Rays, Behavioral, Psychological, at school or in the community etc.) List Evaluations or Tests Performed as follows:					
Type of Evaluations or Test Performed	Date	Where	Name of Provider	Address/Phone	Written Report Received

FAMILY DYNAMICS:

Child lives with:___ Both Parents ___ Father ___ Mother ___ Other (Explain):_______________

Parents are: ___ Married ___ Divorced ___Separated

_________________________ ___ _________________ __________
Father/Stepfather-please underline Age Years of School Completed Occupation

_________________________ ___ _________________ __________
Mother/Stepmother-please underline Age Years of School Completed Occupation

Brothers/Sisters Stepbrothers/Stepsisters	Sex	Age	School	Grade or Occupation	Living in Home Yes or No

Other persons residing in the home (grandparents, etc.)

Does your child get along with other family members?____ If no, please explain:_______________________________________
____
Does your child get along with others his/her age in the neighborhood?____ If no, please explain:_______________________
____
Does your child get along with others at school?____ If no, please explain:____
____
Is the child able to care for self (dressing, eating, personal hygiene, bathroom care, shopping, making change, telling time, using phone, etc.) in manner appropriate for his/her age? _____ If no, please explain:
____

Does your child assume responsibilities within the family, which are age appropriate?_____ If no, please explain:____________
Regular chores/home responsibilities of child:____
What tools, appliances or machinery is your child able to handle?____

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Is your child trusted and able to go about in the neighborhood, to school, and to town alone, appropriately for age?____ If no, please explain:____
Part-time jobs or work child has done to earn money:____
Methods of discipline at home (restriction, spanking, etc.) ____
Has this form of discipline been successful?_______ Please explain:____

____
Special abilities and interests:____

Educational History
At what age did your child enter school? ____ Number of schools attended? _____ Please list below:

School	City and State	Grade Level
Grades Repeated:	Reason(s):	

When did your child begin having problems: ____
Does your child enjoy school? ________________ Being with other students? ______________________________________
Subjects your child likes _________________________ Dislikes ____
Amount of time spent on homework at night: __________ Who helps your child with homework, if needed:_____________________

____

Academic Difficulties

____Reading ____Distractible ____Slow writer ____Following directions
____Math ____Restless ____Poorly organizes ____Remembering information
____Spelling ____Hyperactive ____Finishing tasks ____Short attention span

Please check the following that best describes your child by using the scale to your right.	**Often**	**Seldom**	**Never**	**COMMENTS**
friendly				
even tempered				
trust worthy				
cooperative				
active				
easily goes to bed				
non-aggressive				
gets along well with others				
perfectionist				
sucks thumb				
worries				
stubborn				
easy going				
happy				
outgoing				
bites nails				
likeable				
confident of self				
toilet trained				
continent				
dependable				
awkward or clumsy				
gets along with adults				
polite				
competitive				
sleeps well				
eats well				

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Personal Characteristics: Please indicate how often these behaviors occur in the child by circling the letter that most often describes it. O = Often S = Seldom N = Never

Behavior	O	S	N	Behavior	O	S	N	Behavior	O	S	N
Sleeplessness	O	S	N	Selfishness	O	S	N	Thumb sucking	O	S	N
Nightmares	O	S	N	Lying	O	S	N	Strong fears	O	S	N
Bedwetting	O	S	N	Excitability	O	S	N	Whining	O	S	N
Nervousness	O	S	N	Easily discouraged	O	S	N	Temper tantrums	O	S	N
Walking in Sleep	O	S	N	Convulsive attacks	O	S	N	Playing with sex organ	O	S	N
Shyness	O	S	N	Jealousy	O	S	N	Destructiveness	O	S	N
Showing off	O	S	N	Rudeness	O	S	N	Hurting pets	O	S	N
Refusal to obey	O	S	N	Fighting	O	S	N	Unusually quiet or serious	O	S	N
Stubborn	O	S	N	Bites Nails	O	S	N	Worries	O	S	N
Perfectionist	O	S	N	Awkward/Clumsy	O	S	N		O	S	N

Comments:

If your child has been diagnosed with an orthopedic impairment, please complete the following:
Diagnosis:___
Onset of Diagnosis:___
Is your child seen regularly by an orthopedist and/or neurologist?_____ If, yes how frequently does your child see each specialist?___
If no, when was the last visit with each specialist?___
Please List Durable Medical Equipment your child currently uses:

Does your child use Orthotics (AFO, DAFO, Orthotic braces):___
Date of most recent Orthotics Manufactured with Vendor Name:___

Has your child been seen at a Spasticity Clinic?____ If yes, list name of Spasticity Clinic, dates, locations and recommendations:___

Has your child had any orthopedic surgeries? _____ If yes, please list type, dates, surgeon name and results of surgery:___

Has your child receive Botox Treatments?_____ If yes, please list dates, who administered treatment, locations of injections, and results:___

Does your child participate in PE at school? ____ Is it adaptive PE?___ If so how often is Adaptive PE Services provided

Does your child participate in Adaptive Recreational Activities or Sports?____ If so, please describe:___

Describe how your child moves around environment, at home, in public, school, short and long distances:

Are there any precautions/contraindications?___ If yes, please describe:___

What are your concerns regarding your child's orthopedic impairment and developing skills?___

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If your child is in Pre-School, Ages 3 to 5 years, please complete the following.

Please check the following that best describes your child by using the scale at the right. Does your child exhibit the following behaviors?	**Always**	**Most of The Time**	**Sometimes**	**Not Frequently**	**Never**
Motor Skills					
Difficulty riding a riding toy, with feet pushing or propelling (e.g., big wheels)					
Difficulty or hesitancy in climbing up and/or down stairs alternating feet.					
Dislikes playing with puzzles					
Dislikes or avoids coloring or drawing					
Dislikes playing with small manipulative toys (i.e. beads, bolts)					
Difficulty with the use of a spoon or cup					
Has very messy eating habits					
Seems weaker or tires more easily than other children his age					
Appears stiff, awkward, or clumsy in movement					
Difficulty learning new motor tasks					
Has difficulty getting on coat with zipper or putting on shoes (no tying)					
Uses too much force when playing with toys or interacting with children or pets					
Walks on toes, now or in the past					
Movement and Balance					
Child has difficulty sitting still for an activity					
Appears fearful of going down stairs					
Gets nauseated or vomits from other movement experiences, (e.g. , swings, playground merry-go-rounds)					
Seeks quantities of movement (i.e. swirling or spinning)					
Seeks quantities of stimulation on amusement park rides and swings					
Hesitates to climb or play on playground equipment					
Has trouble or hesitancy in learning to catch a ball					
Dislikes active running games (i.e., tag)					
Rocks him/herself or bangs head when stressed					
Has a tendency to fall					
Has poor safety awareness when moving through space					
Fearful of going down sliding board or on a swing					
Touch					
Seems unaware of being touched or bumped					
Seems overly sensitive to being touched, pulls away from light touch					
Has trouble remaining in busy or group situations (i.e., circle time, recess)					
Complains that clothing is uncomfortable and/or bothered by the tags in the back of shirts					
Resists wearing short sleeved shirts or short pants					
Continues to examine objects by putting in the mouth (past age of 1.5 years)					
Dislikes being cuddled or hugged, unless on child's terms					
Seeks quantities of jumping and crashing					
Avoids putting hands in messy substances (i.e., Playdoh, finger paint, glue)					
Is a picky eater, refuses many foods					
Pinches, bites, or otherwise hurts self					
Often unaware of bruises and cuts until someone calls it to his or her attention					
Seems overly sensitive to slight bumps or scrapes					
Tends to touch things constantly (ex. while walking child rubs hands on wall)					
Frequently pushes or hits other children					

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Please check the following that best describes your child by using the scale at the right. Does your child exhibit the following behaviors?	Always	Most of The Time	Sometimes	Not Frequently	Never
Auditory					
Has or had repeated ear infections					
Particularly distracted by sounds, seems to hear sounds that go unnoticed by others					
Doesn't respond consistently to verbal cues					
Is overly sensitive to mildly loud noises (i.e. bells, toilet flush, phone ringing)					
Is hard to understand when he/she speaks					
Has trouble following 1-2 step commands					
History of delayed speech development					
Bowel and Bladder					
Late in achieving bowel and bladder control					
Has accidents during the day					
If accidents occur, child does not seem to be aware ahead of time that elimination is about to occur					
Social/Emotional					
Does not accept changes in routine easily					
Becomes easily frustrated					
Apt to be impulsive, heedless, accident-prone					
Has frequent outbursts or tantrums					
Tends to withdraw from groups, plays on the outskirts					
Has trouble making needs known in appropriate manner					
Avoids eye contact					

Gross Motor Skills

Please review and complete the section that applies to your child's current age.

If your child is already this age:	Y/N	Is he/she performing these skills?
3 yrs old	Y/N	Sommersaults forward
	Y/N	Rides tricycle
	Y/N	Stand on one foot 3 – 5 seconds
4 yrs old	Y/N	Catches large ball
	Y/N	Descends stairs one foot/step (alternating)
	Y/N	Swings on swing for three minutes, maintaining own momentum, using legs to propel (pump)
	Y/N	Throws small ball a distance of 9 feet
5 yrs old	Y/N	Dribbles ball
	Y/N	Standing broad jump 18-24"
	Y/N	Throws ball overhead with direction
	Y/N	Bounces a tennis ball and catches it after one bounce with each hand (2 out of 4 trials)

Fine Motor Skills:

Please review and complete the section that applies to your child's current age.

If your child is already this age:	Y/N	Is he/she performing these skills?
3 yrs old	Y/N	Cuts with scissors
	Y/N	Copies a circle
	Y/N	Holds pencil with thumb and finger
4 yrs old	Y/N	Demonstrates hand preference (R or L)
	Y/N	Draws a person with three parts
	Y/N	Cuts following a line
5 yrs old	Y/N	Copies a square
	Y/N	Connects two dots
	Y/N	Consistently holds pencil with fingers correctly positioned
	Y/N	Cuts square with scissors

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Self Help Skills:
Please review and complete the section that applies to your child's current age.

If your child is already this age:	Y/N	Is he/she performing these skills?
3 yrs old	Y/N	Undresses without help and dresses with supervision and assist for fasteners
	Y/N	May require prompting for toilet use, as well as assist
4 yrs old	Y/N	Dresses with supervision, may still require some assist with fasteners
	Y/N	Holds spoon with mature grasp
	Y/N	Goes to the toilet alone
5 yrs old	Y/N	Brushes teeth without help
	Y/N	Puts shoes on correct feet
	Y/N	Bathes with reminders and minimal assist for hard to reach parts

Speech and Language.

If your child is already this age:	Y/N	Understanding	Y/N	Expression
3 yrs old	Y/N	Understands simple instructions and concepts like big, little, wet, etc.	Y/N	Uses 4 to 5 words per sentence
	Y/N	Understands the use of common objects when you ask.	Y/N	Answers Yes/No questions correctly
	Y/N		Y/N	Strangers understand between 50 to 75% of what your child says
3 ½ yrs old	Y/N	Understands instructions that include concepts (space, size, and color)	Y/N	Uses 5-6 words per sentence
	Y/N	Points to colors when named	Y/N	Strangers understand about 75% of what child says
	Y/N	Understands concepts like same, different, heavy, empty	Y/N	States name, age, sex clearly
	Y/N	Groups things	Y/N	Uses basic grammar like plurals (cat, cats) and pronouns (I, you, he, she, they) correctly
4 yrs old	Y/N	Knows specific body parts (eyebrow, thumb, etc.)	Y/N	Uses 6-7 words per sentence
	Y/N	Understands where, what, who, why questions	Y/N	Strangers understand 90% of what child says. Minor errors like r, l, th are common.
	Y/N	Understands day/night, simple time concepts	Y/N	Uses present tense (he plays), past tense (he played) plurals (cat/cats), pronouns (I, he, she, we, they).
			Y/N	Tells stories of 2-3 sentences leaving details out
			Y/N	Strangers understand 95% of what child says. errors with s, th, r, l are common.
4 ½ yrs old	Y/N	Understands "counting", not just stating the numbers in order	Y/N	Uses 7 to 8 words per sentence
	Y/N	Counts accurately 1 to 5 items	Y/N	Asks a lot of questions using "wh" words (what, where, why, when, who)
	Y/N	Knows first, second, third, last	Y/N	Asks about people, places, events
			Y/N	Names 6 colors
			Y/N	Strangers understand 100% of what child says. Errors with s, th, r, or l do not interfere with communication process.

In your own words, please describe the primary concerns that you have about your child's development and the goals you wish to accomplish by seeking services at our center:

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