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: ( ) -**

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

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**

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

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

MEDICAL & SOCIAL HISTORY
(SCHOOL AGE - 5 YR S AND OLDER)

Child's Name:_____DOB:_____

PREGNANCY/BIRTH HISTORY

Any problems during pregnancy or at birth (Measles, falls, anoxia, etc.)_____
_____ Place of Birth:_____
Delivery: Full Term____ Premature____ Prolonged_____ Forceps_____ Other_____
If Premature, at what gestational age was child born:_____ Birth Weight_____ Birth Height _____
Describe any complications after birth _____
_____
_____

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?_____
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 temper ed				
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				
Other:				

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?_____
_____

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
Gross Motor Skills					
Seems weaker or tires more easily than other children his/her age					
Difficulty with hopping, jumping, skipping, or running compared to others his/her age					
Appears stiff and awkward in movements					
Clumsy or seems not to know how to move body, bumps into things					
Tendency to confuse right and left body sides.					
Hesitates to climb or play on playground equipment					
Reluctant to participate in sports or physical activity prefers table activities					
Seems to have difficulty learning new motor tasks					
Difficulty pumping self on swing; poor skills in rhythmic clapping games					
Fine Motor Skills					
Poor desk posture (slumps, leans on arm, head too close to work, other hand does not assist)					
Difficulty drawing, coloring, copying, cutting, avoidance of these activities					
Poor pencil grasp; drops pencil frequently					
Pencil lines are tight, wobbly, too faint or too dark; breaks pencil more often than usual					
Tight pencil grasp; fatigues quickly in writing or other pencil and paper tasks					
Hand dominance not well established (after age six)					
Difficulty in dressing; clothing off or on, buttons, zipper, tying bows on shoes					
Touch					
Seems overly sensitive to being touched; pulls away from light touch					
Has trouble keeping hands to self, will poke or push other children					
Touches things constantly; “learns “ though his/her fingers					
Has trouble controlling his/her interactions in group games such as tag, dodge ball					
Avoids putting hands in messy substances (clay, finger paint, paste)					
Seems to be unaware of being touched or bumped					
Has trouble remaining in busy or group situations (i.e., cafeteria, circle time)					
Dislikes being cuddled or hugged, unless on child’s terms					
Movement and Balance					
Fearful moving through space (teeter-totter, swing)					
Avoids activities that challenge balance; poor balance in motor activities					
Seeks quantities of movement including swinging, spinning, bouncing, and jumping					
Difficulty or hesitance learning to climb or descend stairs					
Seems to fall frequently					
Gets nauseated or vomits from other movement experiences (e.g., swings, playground merry-go-rounds)					
Appears to be in constant motion, unable to sit still for an activity					
Bumps into things frequency					

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
Visual Perception					
Have diagnosed visual problem					
Squints often					
Seems sensitive to light					
Dislikes having eyes covered					
Reversals in words or letters after first grade					
Difficulty coordinating eyes for following a moving object, keeping place in reading, copying from blackboard to desk					
Auditory					
Appears overly sensitive to loud noises (i.e., bells, toilet flushing, phone ringing)					
Appears to have difficulty in understanding or paying attention to what is said to him or her					
Easily distracted by sounds; seems to hear sounds that go unnoticed by others					
Has trouble following 2-3 step commands					
Social/Emotional					
Does not accept changes in routine easily					
Becomes easily frustrated					
Difficulty getting along with other children					
Apt to be impulsive, heedless, accident-prone					
Easier to handle in small group or individually					
Marked mood variations, tendency to 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?
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)
6 yrs. old	Y/N	Beginning to jump rope
	Y/N	Skips well
	Y/N	Uses hands more than arms in catching a ball
	Y/N	Strikes a 3 inch ball with a bat when ball is thrown from a distance of 5 feet

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?
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
6 yrs. old	Y/N	Prints name
	Y/N	Prints numbers 1-5
	Y/N	Cuts out simple picture with scissors

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?
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
6 yrs. old	Y/N	Combs/brushes hair with supervision
	Y/N	Ties shoes
	Y/N	Bathes with supervision
	Y/N	Can prepare simple foods with minimal assistance (i.e. cereal with milk)

Speech and Language Skills

If your child is already this age:	Y/N	Understanding	Y/N	Expression
5 yrs. old	Y/N	Remembers most of a story	Y/N	Says name, address, age, gender
	Y/N	Understands all verbal instructions given	Y/N	Uses past (he played), present (he played) and future tense (he will play)
	Y/N	Knows about things used everyday (money, appliances)	Y/N	Tells a story using at least 3 related sentences of 7-8 words each
	Y/N		Y/N	Strangers understand 100% of what child says. Errors with s, th, r, or l do not interfere with communication process.
5 ½ yrs old	Y/N	Understands daily language well enough to have a conversation with a stranger, demonstrating good turn taking, logical thinking, adequate vocabulary and basic grammatical rules. Conversation flows effortlessly from both sides.	Y/N	Strangers understand 100% of what child says. Errors with s, th, r, or l do not interfere with communication process.
			Y/N	Makes up stories using complex language and gives detailed information about self or others.

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: