Dear New Patient and Family:

Thank you for scheduling an appointment for your child at our office. We are greatly looking forward to meeting you. Enclosed are 3 forms for you, 2 of which we would like for you to bring with you on your first visit.

Patient Information Sheet – please complete all areas.

Medical History Form – please complete all areas appropriate to your child.

Family Guide to Theraplay – this is general information about our office for you to read and keep at home.

Please arrive for your first appointment at least 15 minutes early to complete the paperwork process. Remember to also bring your insurance cards and a prescription from your doctor for the therapy that your child is receiving.

While you wait for your visit to come, please check out our website at www.theraplayinc.com to learn more about us. The website can also provide you with a map and directions to the office.

Thank you again and we are anticipating your visit. Have a terrific day!

Enthusiastically,

The Staff at Theraplay, Inc.

West Chester 610-436-3600
Trappe 610-226-6000
Quakertown 215-804-1002
Horsham 215-293-8882
Broomall 610-356-1991

Theraplay, Inc. **Today's Date:____________________**

Patient Information Sheet

*** **PLEASE COMPLETE ALL INFORMATION** ***

PATIENT DEMOGRAPHICS	
Patient's Name	**Date of Birth**
Address	**Soc Sec #**
Caregiver #1 Name	**Home Phone**
Employer	**Work Phone**
Cell Phone	**Soc Sec #**
Email Address	
Caregiver #2 Name	**Home Phone**
Employer	**Work Phone**
Cell Phone	**Soc Sec #**
Email Address	

MEDICAL INFORMATION	
Diagnosis	
Reason for Coming Today	
Primary Physician Information **(who is responsible for primary healthcare of child)**	
Physician Name	**Practice Name**
Address	**Office Phone**
Secondary Physician **(any other physician reports should be sent to)**	
Physician Name	**Practice Name**
Address	**Office Phone**

BILLING INFORMATION	
Person Responsible for Bills **(who is responsible for all unpaid balances, copays, and deductibles)**	
Name	**Phone**
Address	**Soc Sec #**
Insurance Information **(copy all information from your card and give the card to the front desk for copy)**	
Primary Insurance Name	**Policy ID #**
Address	**Group #**
	Phone #
Cardholder's Name	**Relationship to Patient**
Secondary Insurance	**Policy ID #**
Address	**Group #**
	Phone #
Cardholder's Name	**Relationship to Patient**

How did you hear about us?	
Referring person/contact	
Address	**Phone**

Theraplay, Inc.

Medical History Form

Child's Name:	Date of Birth:
Name of Person Completing Form:	Relationship:

PRESENT MEDICAL INFORMATION

Please complete this section completely

Current Diagnosis:		
Who Referred You to Therapy?		
Present Therapy Concerns:		
Other Medical Concerns/Precautions:		
General Health of Your Child: ☐ Excellent ☐ Good ☐ Fair ☐ Poor		
Present Medications:		
Does your child have a history of any seizures?	☐ yes	☐ no
If yes, please explain.		
Has your child ever had any previous therapies?	☐ yes	☐ no
If yes, please explain when, where, and what type.		
Has your child had formal vision testing?	☐ yes	☐ no
If yes, where and what were the results?		
Does your child wear glasses?	☐ yes	☐ no
Is your child presently followed for vision care?	☐ yes	☐ no
Has your child had formal hearing testing?	☐ yes	☐ no
If yes, where and what were the results?		
Does your child have any adaptive/medical equipment?	☐ yes	☐ no
If yes, please explain.		
Does your child follow any special diet?	☐ yes	☐ no
If yes, please explain.		
Does your child have any allergies?	☐ yes	☐ no
If yes, please explain.		

PRESENT ABILITIES/STRENGTHS

Please complete this section completely

Describe the following about your child:
Ability to communicate wants/needs:
Attention span:
Ability to follow directions:
How does your child handle stress? Please describe their coping skills.
Ability to be redirected:
Strength and Balance:
Hand dominance/preference:
Writing skills:
Visual skills:

*** * * Please complete both sides * * ***

INJURY/SURGERY INFORMATION

Please complete this section if therapy is related to an injury or surgical procedure

Date of Injury:

Please explain the injury and how it occurred?

Was surgery performed due to this injury? ☐ no ☐ yes Date of surgery:___________

Where was surgery performed?

Length of hospital stay?

Please explain the details of the surgery.

Did you have any therapy concerns for your child prior to this event? ☐ yes ☐ no

If yes, please explain.

Does your child have any medical or movement precautions because of this? ☐ yes ☐ no

If yes, please explain.

Has your child received previous therapy for this injury/surgery? ☐ yes ☐ no

If yes, please explain

BIRTH HISTORY

Please skip this section if your child is not here for a birth or developmental problem

Was pregnancy full term? ☐ yes ☐ no **Gestational Weeks Completed:** ______ weeks

Type of Delivery: (check all that apply): ☐ vaginal ☐ caesarian ☐ breech ☐ forceps ☐ suction

Length of Hospital Stay:

Was the baby at any time in distress? ☐ yes ☐ no

Birthweight: _____ pounds _____ ounces

Please explain any complications the mother and/or baby had before, during, or after the birth:

Was there any type of diagnosis or medical concern about the baby after birth?

Please describe any family history of developmental or learning problems:

DEVELOPMENTAL HISTORY

Please skip this section if your child is not here for a birth or developmental problem

At what approximate age did your child reach the following developmental milestones (if applicable)?

__________ roll over	__________ say first word	__________ feed self
__________ sit alone	__________ use 2 word sentences	__________ dress self
__________ creep on all fours	__________ speak clearly	__________ use crayons
__________ walk independently	__________ drink from a cup	__________ cut with scissors

Has your child been evaluated by a Developmental Pediatrician? ☐ yes ☐ no

If yes, who and where?

Does your child have a current IFSP/IEP? ☐ yes ☐ no

If yes, please bring provide Theraplay with a copy.

THERAPY GOALS

Please describe what your goals for therapy are. What do you hope therapy will accomplish?

FAMILY GUIDE TO THERAPY

Children's Therapy in a Play Environment

Updated 1/12

WELCOME TO THERAPLAY, INC. Thank you for the opportunity to work with you and your child. All of us here at Theraplay are greatly looking forward to watching your child develop to their fullest potential and will do our very best to facilitate that growth. We have developed the following guidelines to help welcome you to our center and make your therapy experience as enjoyable and easy as possible.

West Chester Center
638 Brandywine Parkway
West Chester, PA 19380

Center Manager: Lori Glancey, MS, OTR/L
Front Desk Coordinator: Dawn Anderson
(610)436-3600, Fax (610)436-3606

Trappe Center
545 W. Main Street
Trappe, PA 19426

Center Manager: Katie Marino, PT, DPT
Front Desk Coordinator: Dana Ditzler
(610)226-6000, Fax (610)226-6003

Quakertown Center
2100 Quaker Pointe Drive
Quakertown, PA 18951

Center Manager: Jennifer Schmidt, DPT
Front Desk Coordinator: Jessica Hill
(215)804-1002, Fax (215) 536-6803

Horsham Center
581 Horsham Road
Horsham, PA 19044

Center Manager: Samantha Gorrell, PT, DPT
Front Desk Coordinator: Elana Graves
(215)293-8882, Fax (215)293-8883

Broomall Center
600 Reed Road, Suite 201
Broomall, PA 19008

Center Manager: Lori Sheppard, MPT
Front Desk Coordinator: Sherri Ryan
(610)356-1991, Fax (610)356-2011

Corporate Administration
Lisa Mackell, PT, President, (610)436-3600, ext. 14, lmackell@theraplayinc.com
Steve Mackell, MS, ATC, CSCS, COO, (610)436-3600, ext. 25, smackell@theraplayinc.com
Maureen Hugel, PT, VP Clinical Operations, (610)436-3600, ext. 12, mhugel@theraplayinc.com
Heidi Woolard, PT, Dir of Outpatient Services, (610)436-3600, ext. 112, hwoolard@theraplayinc.com
Billing Department, (610)436-3600

Website: www.theraplayinc.com

BILLING GUIDELINES

1. It is our goal to provide our patients with the best and affordable therapy services possible. We will verify your insurance benefits specific to therapy, and will explain these benefits to you. **We recommend that you also verify your benefits – the information we receive from your insurance may be incorrect, and you are ultimately responsible for all charges.**
2. We request that all copays, deductibles, and any other fees that are not covered by your insurance be paid at the time of service. We also require the social security numbers of the patient and the subscriber at the time of the first visit, or we will not be able to provide services.
3. If privately paying for therapy, we require that you pay for sessions in full at the time of therapy.
4. We offer a variety of therapy products that may be recommended to you for purchase to facilitate your child's therapy program. You must pay for any item prior to receiving it. We are sorry but we cannot bill you or your insurance for any therapy products.
5. For your convenience, we accept cash, checks, VISA, MasterCard and Discover.

TREATMENT GUIDELINES

1. Theraplay believes in a team approach. Your child will be treated by a number of different staff members, including therapists, assistants, and students, and may interact with aides and volunteers. The team approach achieves greater progress with goals, and better carryover into natural environments. Therapy schedules/assignments may change without notice, in the event of something unforeseen occurring; however, the majority of your appointments will be with exactly who you schedule with.
2. Family members are encouraged to participate in therapy sessions to make them active facilitators in their child's program. Home programs are implemented with family members to ensure the program's success in each unique family environment. If you plan on being active in therapy, please leave siblings at home so that they do not interfere with your child's session. If this is not possible, we request that you remain in our waiting room with your other children.
3. Please be sure to let a therapist know if your child experiences any discomfort or becomes unnecessarily upset due to therapy. Although some procedures may need to be uncomfortable, it is our goal to provide your child with the most enjoyable and fun experience as possible.
4. Parents are welcome and encouraged to remain present during all therapy sessions. However, if you leave during the session, please be sure to return 15 minutes prior to the end of the session so that the therapist may review the session and instruct you in new home activities. Do not arrive back to a session after therapy has ended; our staff has other scheduled children to treat. We cannot take responsibility to watch your child outside of therapy time.

SCHEDULING GUIDELINES

1. All therapy is by appointment only.
2. When scheduling appointments, you may schedule up to one month (4 weeks) of appointments at a time, within your insurance authorization. No appointments will be scheduled outside of your insurance authorization at any time. We know this may cause inconvenient appointments at times, however, this policy is strictly enforced. There is never a guarantee that your insurance will continue to authorize future visits.
3. We strongly suggest families become active participants in the insurance process and contact their insurance company directly regarding pending authorizations. It has been our experience that the insurance companies are far more efficient when a family member becomes involved.
4. We request 24 hours notice for cancellation whenever possible. For each appointment, a full hour of staff time and treatment space are reserved for your child, therefore proper notice allows us adequate time to potentially fill that time slot with another patient. Please call to cancel any appointment – do not email our website to cancel an appointment.
5. There is a $35.00 charge for all appointments that are not cancelled with sufficient notice, and for all no show appointments.
6. If you are late for an appointment, your therapy time will be cut short accordingly, and end at the scheduled time. You will be charged the full amount for the session.
7. Your physician has prescribed therapy for your child as an important tool in your child's development. It is your responsibility to ensure to the best of your ability that your child receives therapy at the recommended frequency by keeping all scheduled appointments, and making up all missed/cancelled visits. Failure to do so will disrupt your child's progress and may interfere with your insurance authorization.
8. If permitted by your insurance, we highly recommend at times double booking appointments if your child receives multiple therapies. When a child is being treated by two or more therapies, it greatly helps the therapists to co-treat with another therapy so that goals can be carried over between all therapies. This is not something that needs to be done all of the time, but randomly throughout therapy is extremely beneficial to your child, and sometimes eases the heavy scheduling burden of so many weekly appointments.

BEHAVIORAL GUIDELINES

Our role is to increase your child's skills through physical, occupational and speech therapy. We do not have a behavioral therapist on staff, and therefore do not provide behavioral therapy. If your child demonstrates extreme behaviors, such as aggression towards self or others, and these behaviors interfere with their ability to participate during sessions, we may require that a support person attend all therapy sessions so that they can carry out your established behavioral plan. It is of the utmost importance that we maintain a safe, therapeutic environment for your child, our staff, and others at all times. If you are in need of behavioral services, we will provide you available resources.

ILLNESS AND INFECTION GUIDELINES

1. Although we do require 24 hours notice for cancellations, we do understand that children do not always provide this notice when becoming ill. Please call our office as soon as you suspect that your child is sick. This is for the safety of your child, our staff, and other children at the office.
2. We request that you keep your child home if any of the following circumstances occur:
    a. Vomit two or more times in the last 24 hours
    b. Fever of above 100 degrees
    c. Unexplained body rash, hives or bumps on skin
    d. Head lice, scabies or other infestation until 24 hours after treatment
    e. Diagnosed infectious condition such as conjunctivitis, chicken pox, coxsackie, staph/MRSA, and whooping cough.