Children's TherAplay
The Children's TherAplay Foundation, Inc.

# 2019 Patient Information Update

Please complete one packet *in its entirety* for each child who is receiving treatment at Children's TherAplay. Return the entire packet to the Children's TherAplay main office, email it to info@childrenstheraplay.org (not your therapist!), or fax it to (317) 872-3234 by 6 p.m. on Tuesday, January 15, 2019 to ensure continuation of services.

Client's Name: _____ Soc. Sec.# _____

Nickname: _____ DOB: _____

Home Address: _____

City, State Zip: _____ County: _____

Home Phone: _____ ❑ Male ❑ Female

Has any of the above contact information changed since last year? ❑ Yes ❑No

## Parent / Guardian Information

**Guardian 1 Name**: _____

Soc. Sec. # _____ DOB: _____

Address (if different than above): _____

City, State Zip: _____ County: _____

Place of Employment: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

**Guardian 2 Name:** _____

Soc. Sec. # _____ DOB: _____

Address (if different than above): _____

City, State Zip: _____ County: _____

Place of Employment: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Caregiver Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

**In case of an emergency, who should we contact?**

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

**Update to existing photo release**

I understand the Children's TherAplay photo policy has been updated. All *general* photo releases will now include the parents and patient *as well as* any of the patient's siblings who are on the grounds of Children's TherAplay. (This does not apply to photos and photo releases that are for administrative use only.)

Parent signature: _____ Date: _____

Patient name: _____

## Medical History Information

Please list your child's **current** referring physician: _____

Phone: _____ Fax: _____

Current therapies: _____

_____

Precautions/restrictions (i.e. seizures, respiratory problems, swallowing, allergies, sensitivities, etc.): _____

_____

Current medications: _____

_____

Surgeries (in last year): _____

_____

Current equipment: _____

_____

## Insurance Information

***We *must* have your most current insurance information. This could effect your child's treatment.***

Please list ALL your current insurance name(s), policy, and group numbers:

| **Primary** | **Secondary** | **Tertiary** |
|---|---|---|
| Company | Company | Company |
| Insured's Name | Insured's Name | Insured's Name |
| Policy # | Policy # | Policy # |
| Group # | Group # | |
| Provider Services Phone No. | Provider Services Phone No. | Provider Services Phone No. |

The 2019 Patient Information Update is not complete until all your insurance cards have been copied and verified. To ensure continuation of services, please remember to present your insurance cards at the main office by 6 p.m. January 15, 2019. Haven't received your insurance card yet? Please see page 3.

Patient name: _____

*This page is only required for those patients who have not yet received their 2019 insurance cards.*

**If you *have* received your new insurance card, please skip to page 4.**

**If you *haven't* received your new insurance card yet, please be sure to complete this page.** You can ensure continuation of your child's services by contacting your insurance carrier, either through their Member Services phone line or by logging in to their website, for the following information.

Insurance company: _____

Insured's name: _____

Policy #: _____

Group #: _____

Provider services (*not* member services) phone number:

Mailing address to file claims: _____

_____

Patient name: _____

# HIPAA Release of Information Form

1. By signing below, I hereby authorize my child's Protected Health Information to be disclosed. The Protected Health Information I am authorizing for disclosure is the following:
   - ❑ "Standard" release of information (Includes evaluation, daily therapy notes and progress notes, all billing records, etc.)
   - ❑ Specific information from my child's chart: _____

   _____

   _____

2. The person or group of people who are authorized to disclose my child's Protected Health Information are as follows: any healthcare provider and/or employee of The Children's TherAplay Foundation, Inc.

3. I hereby request The Children's TherAplay Foundation, Inc. to disclose my child's Protected Health Information to the following person(s) or institutions(s):
   - ♦ Name and address of person or parties to receive your child's medical information:

   _____

   _____

   _____

4. This authorization will expire 365 days from signing, unless an earlier date is indicated. _____

5. I understand that I have the right to revoke this Authorization, if the revocation is in writing, except if:
   - ♦ The Children's TherAplay Foundation, Inc. has taken action in reliance upon this Authorization.
   - ♦ or, if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.

6. I understand that I may revoke this Authorization by sending a written request to:
   The Children's TherAplay Foundation, Inc. ♦ 9919 Towne Road ♦ Carmel, IN 46032

7. I understand that my child's Protected Health Information that is disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.

   By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the disclosure of my child's Protected Health Information in accordance with the terms of this Authorization.

_____ _____

Signature of Parent or Guardian Date

_____

Name & Relationship to Patient

Patient name: _____

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# Attendance Policy

- Cancellations and rescheduled appointments must be made through the Children's TherAplay front office either in person or by calling (317) 872-4166.
- *Emergency cancellations* – these include illnesses, death in the family, severe weather, etc. – should be made at least 24 hours in advance whenever possible.
- All other cancellations are considered *non-emergency* and must be made at least 72 hours in advance, no exception.
- Any *non-emergency* cancellations (with the exception of holidays) made by the patient's family are expected to be rescheduled and made up.
- *No-show*: A *no-show* is defined as any missed appointment for which Children's TherAplay was not notified in accordance with the previously outlined cancellation policies. Three or more *no-shows* within a three-month period may result in the loss of the patient's ongoing scheduled treatment time.
- Tardiness policy: To ensure effective treatment for all our patients, it is very important that patients are checked in no later than seven minutes after the scheduled appointment time. Three or more incidents of tardiness within a three-month period may result in the loss of the patient's ongoing schedule treatment time.
- If 50% or more of a patient's regularly-scheduled therapy treatments are missed, whether for emergency *or* non-emergency cancellations (except for holidays), in a three-month period the ongoing therapy appointment time may be forfeited.
- Children's TherAplay will make every attempt to notify patient families of any cancellations in a timely fashion. Staff cancellations and facility closures do not count against attendance.
- When a patient's primary therapist is unavailable, due to illness, vacation, or schedule conflict, an alternate therapist may provide treatment. In such cases, the attendance policy still applies.

**I have read and agree to the above guidelines as they pertain to my child's plan of care with his/her therapist(s).**

Child's name _____ Date: _____

Parent's signature: _____

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# Discharge Policies and Procedures

As a pediatric clinic providing highly-specialized medical treatment, The Children's TherAplay Foundation works within certain parameters. Discharge / graduation from skilled services occurs when:

- **The child has met his/her goals**

  When patients achieve a functional status that means treatment at Children's TherAplay is no longer medically necessary, it's cause for *celebration* and *graduation* from therapy! This is often bittersweet as it can be difficult to say goodbye, but the focus is always on what's most appropriate and beneficial for the child.

- **The child is functioning at a level that is appropriate for his/her age and diagnosis**

  One of the primary goals for treatment at Children's TherAplay is to help patients achieve *maximum functional potential*, which means the child is functioning at a level, within their disability or condition, in which it is safe and reasonable for the child to complete their everyday and age-appropriate activities. When a child reaches maximum functional potential, it is once again cause for celebration and graduation.

- **The child has reached the weight limit for participation in hippotherapy services as stated in the clinic policy**

  A weight limit is in place *and at the discretion of the treating therapist* to ensure everyone's safety. Children who are able to sit up independently during hippotherapy services may weigh up to 80-100 pounds based upon the child's functional status. A weight limit of 40 pounds is in place for children who require more assistance with sitting and ambulation.

- **The child is unwilling or unable to actively participate in skilled therapy**

  For a child to benefit from skilled therapy, there must be an effective therapeutic working relationship between the child and the therapist, one in which *both* parties are willing participants. If a child is unwilling or unable to actively and consistently participate in skilled therapy, treatment will be discontinued until the underlying issue is resolved.

- **The child is not making progress in skilled therapy**

  As a medical facility, Children's TherAplay *must* be able to demonstrate that a child is consistently making progress towards their goals. Yes, each child makes progress at a different rate, and treatments and plans of care are tailored to reflect these individual

differences. However, if a child's progress towards their goals has stagnated, it is time to talk about discharge/graduation from skilled services. Yes, this may be bittersweet but it is ultimately in the child's best interests.

- **The child no longer requires *skilled* therapy services**

  The physical and occupational therapists at Children's TherAplay have undergone extensive training to be able to provide *skilled* therapy services: therapies that can be performed safely and/or effectively *only by* or *under* the general supervision of a skilled therapist. However, *some* skills do not require a licensed therapist and can be taught to caregivers and parents.

  When a child only requires therapeutic interventions such as range of motion, therapeutic exercises, and sensory home exercise programs – interventions that can be taught to the parent or caregiver – the child does not require *skilled* therapy services anymore.

- **The child's parents / caregivers do not follow through with therapy recommendations / home exercise programs**

  Children's TherAplay therapists see each child for a maximum of two hours per week. For a child to make progress towards his or her goals, the parents and caregivers *must* be involved, and that means following through on any at-home exercises and strategies recommended by the child's therapist.

  When a family is unwilling or unable to implement the at-home programs recommended for their child, it is for discharge from skilled therapy.

- **The child demonstrates unsafe behavior**

  Safety comes first, and that includes safety for both the child and the Children's TherAplay staff. If a child behaves in an aggressive way (such as biting, kicking, hitting, or pinching) towards the human or equine staff or demonstrates unsafe behavior on or around the therapy horses, treatment will be discontinued until the issue is resolved.

**I have read and agree to the above guidelines as they pertain to my child's plan of care with his/her therapist(s).**

Child's name _____ Date: _____

Parent's signature: _____

## *Optional*

As a United Way of Central Indiana partner agency we are required to request the following information.

**Clients Served by the Agency**

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____

Home Address Street: _____

City: _____ ZIP Code: _____

Gender: _____ Race: _____

Ethnicity - Hispanic or Latino Origin: _____

Number in Household:_____

School District Child Attends: _____

School Child Attends: _____

Child's Grade Level: _____ Anticipated HS Graduation Year: _____

***Thank you!***
***Remember to return all eight pages to the Children's TherAplay main office, email them to info@childrenstheraplay.org (not your therapist!), or fax them to (317) 872-3234 by 6 p.m. on Tuesday, January 15, 2019.***