Sonoran Sun Pediatric Therapy

What to Expect With Us!

Setting Appointment:

During our new patient process, we will obtain personal information, insurance information, and physician information. Once we have the all pertinent information, our staff will schedule your child's appointment. The first appointment will be an evaluation for the selected therapy to determine if therapy is necessary. An individualized treatment plan will then be developed for the patient.

Required Documents Prior to 1st Appointment:

- Referral from pediatrician
- Any previous therapy notes (Evaluations, IEPs, MBS, progress notes, hearing screening etc.)
- Prescription from the pediatrician for therapy services

*Without all of these, we are not able to request authorizations from insurance companies for the patient's appointments. It is a company policy of Sonoran Sun Pediatric Therapy, LLC. to have these on file for all patients being seen in our clinic, and is not specific only to patients whose insurance requires authorization for services.

What to Bring to Your Appointments:

- Copy of IEP (if applicable)
- New Patient Paperwork, Doctor Referral, Doctor Prescription for therapy services
- Insurance Card(s)
- Driver's License
- Payment needed for copayments, account balances, or self-pay options
- Make sure the patient has on comfortable shoes; sneakers are best for running and balance activities
- Socks are required for any interactions within the sensory gym.
- **Feeding Evaluation Requirements:** minimum of 2 foods the patient will eat, 2 foods he/she will not eat, and at least 1 beverage he/she will drink.

Evaluation Process:

- Make sure the patient is well rested and wears comfortable shoes
- For sensory gym interaction, bring or have the patient wear socks
- If the patient wears glasses or corrective lenses, please make sure they wear them
- Parent or guardian is required to be present during entire evaluation (may be asked to remain outside the patient's field of vision for testing)
- If observing in the room, it is important not to interrupt testing with questions or attempt to correct the patient during testing as it may interfere with results
- During parent/guardian interview, evaluators will encourage caregivers to ask questions, make comments, discuss concerns while the patient is playing
- Following the evaluation, we ask that you give therapists 7 days to complete the report. Then allow up to 2-3 weeks to obtain authorization from your insurance company.
- Once the evaluation is written and authorization requirements are met, our staff will contact you to schedule accordingly with the treatment plan outlined by the therapist.

Sonoran Sun Pediatric Therapy

Patient Registration

(Please Print)

Date:

DEMOGRAPHICS

Last Name: First Name: M.I.:	D.O.B.: Age: Sex: M or F
Social Security Number:	Ethnicity: Race: Language:
Street Address:	City, State, Zip
Is Patient: Biological Adopted(date of adoption_____) Foster(beginning foster date _____)	Home Phone: Mobile Phone:
Patient lives with: Birth Parents Foster Parents Adoptive Parents Parent/Step-parent One Parent Other_____	Communication Preference: Mobile Home Email
Diagnosis from Pediatrician:	Emergency Contact Name: Phone Number:
Email Address:	Emergency Contact Relationship to Patient:
Guardian Name (Last, First):	Guardian Name (Last, First):

PRIMARY CARE PHYSICIAN

Primary Care Physician:	Facility:
Phone Number:	Fax Number:

PRIMARY INSURANCE

Insurance Company:	Provider Phone Number:
Subscriber Name:	Relationship to Insured:
Subscriber SSN:	Subscriber DOB:
Group Number:	Policy Number:

SECONDARY INSURANCE

Insurance Company:	Provider Phone Number:
Subscriber Name:	Relationship to insured:
Subscriber SSN:	Subscriber DOB:
Group Number:	Policy Number:

Patient Name:

D.O.B: Age:

MEDICAL HISTORY

Has the patient had any of the following? (If yes, please indicate date and/or what occurred):

Y	N	Chronic Ear Infections:	Y	N	Seizures:
Y	N	Difficulty Passing Urine/Stool:	Y	N	High Fevers:
Y	N	Asthma:	Y	N	Allergies: Wheat (play doh), Dairy, laytex, Nuts
Y	N	Frequent Colds/Infections:			Other:
Y	N	Surgery/Hospitalization:	Y	N	Vision Difficulty: Glasses? Y or N
Y	N	Unusual Illness:	Y	N	Hearing Difficulty:
Y	N	Serious Accidents:	Y	N	Tubes in Ears:
Y	N	Medical Precautions? (Please explain)	Y	N	Coordination Problems:

Adaptive equipment needs: (hand splint, AFO, glasses, wheelchair, oxygen, hearing aids, other):

Recent dental work? (Cleanings, extractions, etc.)

Please list any allergies:

Please list current medications:

PRENATAL HISTORY

Y	N	Any difficulty during pregnancy?	Length of pregnancy (in weeks):
Y	N	Did mother take any medications and/or drugs during pregnancy?	Did mother receive prenatal care?
Y	N	Did mother smoke or use alcohol during pregnancy?	
Y	N	Any difficulty during delivery?	After delivery?
Y	N	Premature birth?	
Y	N	NICU?	

Type of birth: Vaginal Cesarean

DEVELOPMENTAL HISTORY

What grade is the patient in?_____

What does the patient like to do? _____

What does the patient have difficulty doing? _____

When did your Patient begin the following?

Sitting without support	< 5 mos.	5 – 8 mos.	> 8 mos.
Crawling on hands and knees	< 6 mos.	6 – 9 mos.	> 9 mos.
Walking unassisted	< 10 mos.	10 – 18 mos.	> 18 mos.
Saying first few words	< 10 mos.	10 – 16 mos.	> 16 mos.
Talking in simple sentences	< 15 mos.	15 – 36 mos.	> 36 mos.
Staying dry during the day	< 24 mos.	24 – 40 mos.	> 40 mos.

Has your Patient received therapy in the past?

If so, please write date of last visit or current.

Therapy	**Home**	**Clinic**	**School**
Occupational			
Speech			
Feeding			
Physical			

Behavioral Characteristics/Temperament:

_____

Sonoran Sun Pediatric Therapy

Physical Therapy Questionnaire

(Please Print)

Patient Name: D.O.B. Age: Date:

Diagnosis from Pediatrician:

Main Concerns: (Please circle) Gross Motor Skills Fine Motor Skills Sleeping Language Development Social Skills Eating Play Skills Temperament Sensory Integration Independent Living Skills

Frustrations(list) _____ Fears (list)_____

Do you feel that any part of the patient's development is slower than average? If yes, explain:

Were eating/feeding schedules easily established? If no, explain:

At what age did the patient consistently sleep through the night? Approximately, how many hours of sleep per night?

Was the patient a fussy baby after 6 months of age? Y or N If yes, please indicate if reason why was identified:

What difficulties does the patient currently have? At what age did you notice the patient experiencing difficulties? _____

Have the patient's teachers mentioned any concerns? (physical, behavioral and/or developmentally)

Family history of similar issues? Y or N If so, who and what difficulties?

Please indicate which tasks your child is unable to complete independently:

__ Sitting independently
__ Walking
__ Standing Up
__ Running
__ Jumping
__ Crawling
__ Throwing/Kicking a ball
__ Catching a ball
__ Using stairs, explain _____

Has your child had any fractures or injuries in the past? No___ Yes___
Any x-rays or imaging done in the past? No___ Yes____ If yes, explain:

_____

_____

Do you feel that your child has trouble with keeping up with other children their age? No___ Yes___ If yes, explain:

_____

Please provide any other information about your child that the therapists should know. (include what goal you are hoping to achieve from therapy):

_____

_____

Sonoran Sun Pediatric Therapy

Records Consent

Patient Name: _____ D.O.B.: _____ Date: _____

☐ By checking this box, you agree to allow the exchanging of medical records with other physicians treating the patient. We will send copies of progress reports, evaluations, recommendations, letters of medical necessity, etc., to pediatricians/specialists when necessary.

Please list individuals below that you allow Sonoran Sun Pediatric Therapy to discuss the patient's medical information with:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Please list individuals below that you allow Sonoran Sun Pediatric Therapy to discuss the patient's account/billing information with:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

By signing this form, you agree to allow the above individuals to call in/ask us about the patient's medical/billing/account information. Also, you acknowledge that, if at any point, you do not want information released to the above individuals, it is your responsibility to update this form on file.

_____ _____ _____

Parent/Guardian Signature Printed Name Date

Sonoran Sun Pediatric Therapy

Our Clinic Policies

Please initial/check the boxes below next to each policy and sign at the bottom to acknowledge the policies we have set in place. By signing this form, you have read and agree to follow our policies.

Financial Policy

☐ As a courtesy, Sonoran Sun Pediatric Therapy, LLC will bill your insurance for services provided. Please note that a prior authorization is NOT a guarantee of payment. Any fees/charges that your insurance company puts towards your deductible or coinsurance will be billed to you. All copayments are due upfront prior to your appointment. In the event that your insurance company deems the services as non-covered benefits, the balance will be billed to you at self-pay rates. For more information on self-pay rates, please contact our billing department. If checks are used as a form of payment and they are rejected by the financial institution due to "No Sufficient Funds", there will automatically be a $50 fee assessed to your account balance. By signing this form, you give us permission to provide documentation and proof of services to your insurance company on your behalf in attempt to collect payment.

3 Strike No Show policy

☐ Sonoran Sun Pediatric Therapy, LLC has a "3 Strike No Show Policy". Each no show generates a **$25 fee** on your account. This policy is ***non-negotiable,*** regardless of the reason for the no show. In the event that you no show 3 times in a quarter (January – March, April – June, July-September, or October – December) the patient will be discharged from Sonoran Sun Pediatric Therapy, LLC. After 90 days from being discharged, you may call in to see if we have an opening for the patient to resume therapy with our clinic. This policy is in place to ensure all of our patients are presented with the same equal opportunity to receive the assistance and therapy they need.

24 Hour Cancellation Policy

☐ Here at Sonoran Sun Pediatric Therapy, LLC., we require a **24-hour** cancellation notice for any and all appointments. This policy is ***non-negotiable*** regardless of the reason for the cancellation. If you are 5 minutes late for speech or feeding appointments or 10 minutes late to occupational therapy appointments, we will have to cancel and it will be considered a late cancellation. We understand that things happen due to illness, car trouble, family emergencies, etc. This is why Sonoran Sun Pediatric Therapy, LLC. assesses the **$25 fee** on the 3rd late cancellation.

_____ _____

Parent/Guardian Signature Date

_____

Patient Name Printed

Sonoran Sun Pediatric Therapy

Notice of Privacy Practices

This notice is in compliance with HIPPA regulations to inform you of how medical/protective health information will be used/disclosed and how you may obtain access to it.

By law, we are required to provide you with a copy of our Notice of Privacy Practices (NPP). This notice will describe how Sonoran Sun Pediatric Therapy, LLC. may use or disclose the patient's medical information. You can also find how to obtain access to this information below.

As a patient/parent/guardian of the patient, you have the following rights:

1. The right to obtain a copy of your information
2. The right to inspect your information
3. The right to request/make changes/corrections to your information
4. The right to request that your information be restricted
5. The right to request confidential communication
6. The right to report unauthorized disclosure of your information
7. The right to a hard copy of our NPP

Sonoran Sun Therapy, LLC assures that your protected health and medical information is secure with us. In this notice, you will see how we ensure to keep your information private. If you have any questions or concerns, please contact the clinic:

Sonoran Sun Pediatric Therapy, LLC
623-900-7824 – Main
623-321-1981 – Fax
office@sonoransuntherapy.com

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of Sonoran Sun Pediatric Therapy, LLC's NPP (Notice of Privacy Practices). I understand that if I have questions or concerns, to contact the clinic. In addition, I understand that Sonoran Sun Pediatric Therapy, LLC will provide me with any updated versions of this notice."

_____ _____

Parent/Guardian Signature Date

_____

Patient Name (Printed)

Revised 02/2019