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.

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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:

If your child's therapist is absent and there is an opening at the same day/time with another therapist, do you give Sonoran Sun permission to schedule your child with that therapist? If no, we will call you about other time slots.	YES	NO

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

Speech Therapy Questionnaire

(Please Print)

Patient Name:	D.O.B.	Date:
Diagnosis from Pediatrician:		
Language other than English used at home:	Does the patient speak this language:	
Does the patient understand this language:	Who speaks this language?:	
Which language does the patient prefer to speak at home:		

Other Children in the Family:

Name	Age	Sex	Grade	Speech/Hearing Problems

Do you feel the patient has a speech/hearing problem?	Y	N	Explain (if yes):
Has he/she had any hearing screenings?	Y	N	Explain (if yes):
Has he/she had any therapy evaluations?	Y	N	Explain (if yes):
Has he/she received ongoing therapy?	Y	N	Explain (if yes):

Is he/she aware of/frustrated by any speech/language difficulties?

What do you see as the patient's most challenging area at home?

What do you see as the patient's most challenging area in school?

How does the patient communicate? (body language, sounds, words, sentences, AAC device, etc.)

What concerns do you have about the patient's speech/language skills?

How much of the patient's speech do you/others understand? (0-25%, 25-50%, 50-75%, 75-90%, 90-100%)

Can the patient follow simple directions? How many steps?

Does the patient consistently respond to his/her name?

Does the patient answer yes/no questions? Does the patient answer who/what/where/when/why questions?

If AAC (augmentative communication) is used, what program? What level/how many buttons on screen?

Do you have any concerns for the patient's social skills? (i.e. does he/she greet others/speak with other children and adults/make appropriate eye contact?)

Do you have any concerns about the patient's voice? (pitch, volume, quality)

Do you have any concerns about the patient's fluency/stuttering?

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 2024

Our clinic's goal is to provide high-quality and effective therapy services. Your responsibility in this goal is agreeing to have your child consistently attend their scheduled therapy sessions. Consistent attendance is crucial in your child's success and progress in therapy. We understand that sometimes unexpected events happen and you may need to cancel or reschedule your appointment.

Appointments are in high demand and many children are waiting for open appointments. We ask that you provide us with adequate notice of any cancellation or rescheduling so we have the opportunity to offer that appointment to another child.

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 agreed 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**. If the Insurance Company does not pay for treatment, you will be emailed a bill and the card on file will be charged within 2 days for the contracted rate or cash rate.

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 office manager or 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 an attempt to collect payment.

No Show/Call Policy

☐ Sonoran Sun Pediatric Therapy, LLC has a "No Show Policy". **Each no show generates a $50 fee on your account.** This policy is ***non-negotiable,*** regardless of the reason for the no show. If you have a co-treat appointment, this will count as (2) appointments and a **$100** fee will be charged to your account.

Late 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. **Each late cancellation will generate a $50 fee** automatically charged to your account unless the appointment is rescheduled.

We charge patients a $50 fee for late cancellations and no shows, due by the next visit. If you are ill or have an emergency, we will consider this on an individual basis. (Please contact our Office Manager if you have any questions.)

Late Cancellation = less than 24 hour notice
No Show = canceling less than 2 hours before appointment or no show/no call

Attendance Policy

☐ While we are working together, we set aside 1-2 hours weekly for you and your child. In exchange, you are expected to arrive on time and regularly attend your scheduled appointments. If you are excessively late or cancel multiple visits, you will be removed from the schedule.

Reasons for removal include:

- Excessive late cancellations
- No show appointments

Appointment Policy

☐ Parents and/or guardians must walk the patient into the clinic and sign him/her in on the sign in sheet. During their session, parents may wait in their car or in the waiting area, however, **our insurance does not permit parents to leave the property.** If a parent leaves the property, and the child is left unattended, the Surprise PD will be contacted.

All children must be escorted to and from the building by either their care-giver, (parent, guardian, case worker, etc.) or by the clinic service provider. If you choose to wait in your vehicle in our parking lot, please inform the front desk of the make, model and color of your vehicle, and where it is located.

_____ _____

Parent/Guardian Signature Date

_____

Patient Name Printed

Updated CC File -Autopay Agreement Policies 2024

I, _____, agree to allow Sonoran Sun Pediatric Therapy to keep my credit card information (listed below) on file.

I hereby affirm that I am the owner of the below referenced card and that my name is listed on the front of the card. I hereby agree that any outstanding charges for services will automatically be charged to the card on file the 5th of every month. The amount for services will be provided to you, prior to or on the date of service. An email receipt will be sent out upon charge.

***Any cancellations or no-show fees will be automatically charged $50.00 to the card on file.**

Cardholder Information

Name _____

Address: _____

City: _____ State:_____ Zip:_____

Phone Number: _____

Card Number _____

Expiration Date _____ CCV _____

Patient Name: _____ DOB: _____

_____

Parent Name Printed

_____ _____

Parent/Guardian/Cardholder Signature Date

Sonoran Sun Pediatric Therapy

Speech Therapy · Feeding Therapy · Occupational Therapy

Photo / Video Release Form

Here at Sonoran Sun Pediatric Therapy, we often like to share our triumphs and help other families learn how to be successful at home. By doing this we may want to post videos and/or photos of your child!

If you are on board with having your child on our social medias of Instagram, Twitter, Facebook, YouTube, and our website, then please fill out the information below.

Today's Date: _____ D.O. B: _____

First & Last Name: _____

If you are **NOT** on board with having your child on our social medias of Instagram, Twitter, Facebook, YouTube, and our website, then please fill out the information below.

Today's Date: _____ D.O. B: _____

First & Last Name: _____

Parents Signature: _____

Thank you,

Sonoran Sun Pediatric Therapy

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