Family Therapy Solutions
2120 Bryan Valley Commercial Dr.
O'Fallon, MO 63366
314-774-1859

Date_______________

A. **IDENTIFICATION**

Client:____ ______________________
Last First

Address_________________________________City___________State____Zip_______

Birthday____/______/______Sex__________Telephone_(___)____________________
Father: Name______________________________ Occupation_________________
Mother: Name______________________________ Occupation_________________

List of others residing in the home:

Name ***Relationship*** ***Age*** ***Grade***

Referred by: ____

B. **INSURANCE INFORMATION**

Name of insurance company and plan type_________________________________
ID #_______________________________
Group # ____________________________
Secondary insurance company and plan type______________________________
Insured's name and DOB____
Insured's Employer____
Patient diagnosis code________________(Dr will be able to provide this)

C. **BIRTH HISTORY**

Age of mother at time of delivery____ Prenatal health of mother__________________
Complications during pregnancy or delivery____________________________________
____
____
Birth Weight__________________Prolonged stay in hospital_____yes/no______________
If yes, how long?____
At about what age did the client do the following:

Sit alone__________ Crawl_________ Rollover_________ Walk alone_________

Feed Self_________ Toilet Train_________ Walk up stairs w/ a railing_________

D. **HEALTH HISTORY**

Has your child ever had any major illness?____

Has your child ever had surgery?____

Describe your child's eating issues (chewing, swallowing, stuffing, texture issues etc.)____

Does your child have a diagnosis and if yes,explain____________________________________

Is your child usually in good health?_______________Does he/she take any medications? If yes, please list____

E. **SOCIAL DEVELOPMENT**

List 5 words that best describe your child's personality, disposition & behavior

1. 2. 3. 4. 5.

Does your child get along with other children? Please explain____

How does your child communicate with other children?________________________________

Adults?____

F. **SPEECH THERAPY** ***(Please fill out this section only if you are a speech therapy client)***

During the first year, did your child coo & babble?____________________________________

At what age did they say their first word?____

Did they continue adding words?____

Did speech development ever seem to stop?____

Can you understand your child?____

Can others understand your child?____

How does your child communicate their wants and needs?_____________________________

What words do they consistently use on a daily basis? (if too many to list, give an estimated number)____

Does your child have difficulty hearing?____

Do you notice any consonant sounds that your child does not use in their speech?____

Please describe your child's speech and your concerns__________________________________

G. **THERAPY GOALS**

Please explain what you would like to see addressed in your child's therapy sessions?____

Does your child have any motivators that could be used during therapy?______________

Family Therapy Solutions, LLC

At Family Therapy Solutions we strive to help each child reach their personal goals & milestones. To make sure each child can do this in a safe & loving learning environment we have established the following policies & procedures for our center.

Policies for Family Therapy Solutions:

- Our therapists will do their very best to be on time. Please be prompt for your appointment. If you drop your child off, please return at least 5 minutes before their session is scheduled to end. You MUST leave a phone # where you can be reached w/ the receptionist.
- Please remain seated w/ your child in the waiting area until their therapist is ready to begin their session.
- 24 hours cancellation notice is required, "no shows" will be charged for a normal session
- Returned checks will result in additional $35 fee for our incurred expenses
- All co-pays are due at the time of services rendered. All balances must be paid in order to continue therapy services.
- All children must be fever & symptom free for at least 24 hours before returning to the center for therapy. Please call & we will be happy to reschedule your session.
- If your child is not potty trained, please leave the appropriate supplies with the receptionist or therapist.
- Please understand that in order to build a trusting relationship w/ your child, you may be asked to leave the therapy room during treatment. Please respect our therapists' wishes in this situation as it is in the best interest of your child. Our therapists are always willing to educate parents/guardians on the therapy techniques & strategies used during the session. All of our therapy rooms have one-way windows, so please feel free to observe your child.

Additional information

- We are closed on Thanksgiving Day, the day after Thanksgiving, Christmas Eve & Christmas Day, New Year's Eve & New Year's Day. We are also closed the week between Christmas & New Year's Day.
- Inclement weather policy-if the Ft. Zumwalt or Wentzville School District's are closed, we are closed. This is to ensure the safety of your children & our therapists.
- Cell phones will not be allowed in therapy rooms.

Please sign & return this form to us on your child's first visit to our center.

Signature____ Date______________

Family Therapy Solutions, LLC
2120 Bryan Valley Commercial Dr.
O'Fallon, MO 63366
Phone: 314-774-1859
Fax: 636-294-5044

Authorization to treat and financial responsibility

I request occupational and speech therapy treatment from Family Therapy Solutions, Inc. I consent to routine diagnostic evaluation and therapy services as deemed medically necessary.

I understand that my signature requests that payment be made to the above named provider and authorizes release of information to insurer that is necessary to pay the claim and preauthorize treatment. A photocopy of this assignment is to be considered as valid as an original.

I agree to a charge of $ 75 for missed appointments, including appointments that are canceled with less than 24 hours notice. I understand that I am financially responsible for any required co-payments, deductibles and services and/or charges not paid or covered by my insurer.

I understand I am responsible for obtaining all precertification required by my insurance company. I authorize the release of information to my insurance company, including Medicaid and my attending physician. I hereby authorize my insurance benefits to be paid directly to Family Therapy Solutions, Inc. If signed by guardian or parent for a patient, this is an authorization for medical treatment of a minor.

Payment of services. Payment for services rendered is ultimately the patient responsibility. Your insurance policy is basically a contract between you and your insurance company. It is **YOUR** responsibility to give us the correct information about your insurance company. You must comply with the rules of your insurance company such as a valid referral form and pre-certification of testing and surgery in order for your claim to be paid. Plan eligibility for procedures does not always confirm certification, authorization or payment of service. We will file your insurance claim, but for claims denied because of failure to comply with the insurance companies requirements, you will be responsible for paying the denied amount. For patient balances and self pay accounts, we accept cash and checks.

Non covered services. Not all insurance plans cover all services. In the event that your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. We recognize government plans require and "Advance Beneficiary Notice" which we will provide.

No insurance coverage. If you do not have insurance coverage, we expect payment in full before service is rendered. In certain circumstances, payment plans may be made in advance of your visit. If you default on your promised payment, our policy is to refer you to a collection agency.

I have read this Authorization and I agree to be bound by its terms.

______________________________ ________________________

Signature of patient (or responsible party) Date

Authorization to Bill Insurance

By signing this consent form I agree to & am fully aware of the following:

- I have agreed to Family Therapy Solutions, Inc. billing my insurance company for services rendered.
- I am aware that for evaluations the rate is $250 per evaluation for insurance customers & that my insurance company will be billed for this amount. I am also aware that these services usually require a preapproval.
- I am aware that the rate per hour for insurance customers is $150 per session for ongoing therapy and my insurance company will be billed for this amount for each session.
- I understand that by Family Therapy Solutions, Inc. calling my insurance company and getting approval for services & information DOES NOT MEAN ALL SERVICES WILL BE COVERED.
- I understand that I am FULLY financially responsible for all co-payments, co-insurance payments and any deductibles that must be met.
- I understand that Family Therapy Solutions, at this time, is an out of network provider and that my out of pocket expenses may be higher.
- I understand that if there are NO insurance benefits available to me or that if I chose not to utilize them, that the rate per session is $75. I understand that once my insurance is billed, even if they refuse coverage, I am 100% responsible for my balance of $150 per session & $250 per evaluation.
- Your insurance policy is a contract between you and your insurance company. It is YOUR responsibility to give us the correct information about your insurance company. You must comply with the rules of your insurance company. If you choose to appeal a claim denial, it is your responsibility to get reimbursement from your insurance carrier. It is expected that payment will be made to Family Therapy Solutions by you in this event and you must appeal to your insurance company on your own for reimbursement.
- We will file your insurance claim, but if a claim is denied because of failure to comply with the insurance companies requirements, you will be responsible for paying the denied amount. For patient balances and self pay accounts, we accept cash and checks.
- In certain circumstances, payment plans may be made in advance of your visit. If you default on your promised payment, our policy is to refer you to a collection agency.
- All accounts past 60 days will be turned over to collections.

  I have read this Authorization and I agree to be bound by its terms+

_______________________________________ ____________________

Signature of patient (or responsible party) Date