



Welcome to Village Therapy Works!

We are pleased that you have chosen our facility to be your child's provider for Speech and Occupational Therapy. Our services cover a vast spectrum of speech, language, learning, motor and sensory disorders to meet your child's needs. Our office manager and therapy staff will be happy to answer any of your questions. We have been in the community servicing preschool and school age children for the past 20 years.

Speech and Occupational Therapy is a cooperative effort. Working together with your therapist will help your child progress to his/her fullest potential. Our mission is for all children to develop their own unique learning abilities to be successful in their environment.

What to expect

Evaluations

The evaluation can take ½ hour to 3+ hours depending on the nature of the problem. We gather information during the phone interview and parent questionnaire in an attempt to determine the necessary tests to be administered; however, there are occasions when additional testing is required. Therapy may be implemented before reports are completed, as it can provide us with further information about your child. Reports usually take up to 2 weeks to complete and a follow-up consultation will be scheduled to discuss the results. Re-evaluations may be conducted upon request or every 6 months as needed.

Therapy

The best way to achieve success in the therapeutic process is with consistent attendance and commitment from the parent and child. Therapy is a partnership between you and your therapist. Your therapist commits her time and organizes treatment activities and homework to help meet your child's goals. Success depends on regular attendance and commitment to completing homework assignments. Progress reports will also be provided upon request or every six months as needed.

Outside Related Conferences/Referrals

Recommendations and referrals to specialized services will be made if we see that your child needs additional support. Attendance at school conferences can be arranged for a fee to compensate your child's therapist for their time and input.

Pre-authorization

We attempt to pre-authorize all therapy services through the primary care physician (PCP) and insurance companies. Sometimes this can take 2 weeks to 2 months depending on your insurance company. We recommend that you actively participate in the pre-authorization process by calling your insurance company to check the status of your authorization. Once the authorization is approved, there may be limitations of visits approved. We ask that you keep informed of those dates/visits.

Failure of Insurance Company to Respond to Claims

If your insurance company fails to respond to a claim within 60 days of your filing date, **you are responsible for payments that are due at that time.**

Advocacy

You are the policyholder. As such, the insurance companies pay more attention to you than they do to us. You have chosen their company and pay for your premiums to them. It often becomes necessary for families to advocate on their own behalf to obtain insurance coverage.

Pay attention to your EOBs (explanation of benefits) as claim denial is not a final determination.

Insurance companies often deny services initially to delay payment responsibilities. A claim denial is a red flag and requires immediate action. You can appeal a claim denial. Discuss it with your therapist, physician, and our billing staff.

Speech, Language & Occupational Therapy
that "works" for you and your child

CASE HISTORY

Patient's name: _____ Date of Birth: _____

Parent's name(s): _____

How were you referred to Village Therapy Services? _____

Child's Physician: _____ May we send the doctor a copy of the report? yes no

Physician's Address: _____ Phone #: _____

Describe your primary concern? _____

When was the problem first noticed? _____

What is your child's reaction to the problem? _____

How do you and others in family react to this problem? _____

What do you think the causes the problem? _____

What has been done about it? _____

FAMILY INFORMATION: List siblings (list any problems they may have and how they interact with your child)

Name Age Grade How do they interact with child? Are there any learning problems?

| Name | Age | Grade | How do they interact with child? | Are there any learning problems? |
|------|-----|-------|----------------------------------|----------------------------------|
| | | | | |
| | | | | |
| | | | | |

Is there any family/relative history of speech, language, hearing, learning, or motor difficulties and/or genetic/syndrome? yes no

If so, explain _____

List other caregivers and relationship to your child: _____

What languages are spoken at home/school? _____

Is there any other family related information (disabilities, illnesses, deaths, etc.) that may be important to know?

BIRTH HISTORY

Instructions: Please elaborate if answer is "YES".

YES NO

| | | |
|--|--|---|
| | | Were there any illnesses, injuries, fainting spells, bleeding, anemia, operations or any other difficulties during pregnancy? |
| | | Were any drugs, alcohol or medication taken during pregnancy? Specify: |
| | | Was the birth premature? (give months and weight) |
| | | Was it an unusual delivery? Breech? Caesarian? |
| | | Was the labor abnormally lengthy? (8+ hours?) |
| | | Was medication &/or instruments used during delivery? Specify. |
| | | Was your child considered a low birth weight? (under 4lbs.) |
| | | Were there complications? (i.e. Lack of oxygen, Cyanosis, Jaundice, Congenital defects, lethargic) Specify: |
| | | Were there any feeding difficulties? Specify: |
| | | Was your child bottle fed? |
| | | Was your child breast fed? |
| | | Did your child have problems sucking? |
| | | Did your child have problems swallowing? |
| | | Did your child have an extended hospital stay following birth? |

Please state any unusual problems before or after the pregnancy.

DEVELOPMENTAL

Please list the approximate age achieved.

| PHYSICAL | SELF-HELP | VERBAL |
|-------------------|-----------------|--------------------------------|
| Age | Age | Age |
| Sat (unsupported) | Ate table food | Babble & Coo |
| Crawled | Solid food | Points to picture |
| Stood | Fed self | Used single words with meaning |
| Walked | Dressed self | Used sentences (3-4 words) |
| | Bladder control | Asked questions |
| | Bowel control | |

Does the child prefer to use gestures? Give examples: _____

MEDICAL

Has your child had any of the following? Please give dates and indicate whether your child had the illness or was immunized.

| YES | NO | PLEASE EXPLAIN | DATE |
|------------|------------------------|---|------|
| | | Meningitis | |
| | | Measles/Mumps | |
| | | Chicken Pox | |
| | | High Fevers | |
| | | Croup | |
| | | Diabetes | |
| | | Lung or Bronchial difficulties | |
| | | Heart Trouble | |
| | | Seizures/Convulsions (indicate when, how often) | |
| | | Allergies: Please list (ie: peanuts, latex, seasonal) | |
| | | Asthma | |
| | | Tinnitus | |
| | | Colds | |
| | | Influenza | |
| | | Tonsillitis | |
| | | Sinusitis | |
| | | Headaches | |
| | | Excessive Vomiting/Reflux | |
| | | Has your child had surgery or a medical procedure? Give date(s) and describe: | |
| | | Has your child had a vision examination? Diagnosis: Name of Facility or Doctor | |
| | | Has your child had an audiological (hearing) examination? Diagnosis: Name of Facility or Doctor | |
| | | Has your child had ear infections? How many before the age of 2? How many within a year? | |
| | | Is your child currently on medication? If so, please list below. | |
| Medication | Dosage(mg & times/day) | Purpose | |
| | | | |
| | | | |
| | | | |

Does your child have any disorders or illnesses other than mentioned? If so, specify: _____

ACADEMIC INFORMATION

Has your child received previous diagnostic evaluations? Yes No

If "Yes" please explain.

| Date | Type of testing | Results: |
|------|-----------------|----------|
| | | |

YES NO

Please elaborate.

| YES | NO | | Please elaborate. |
|-----|----|--|-------------------|
| | | Does your child attend school? School name, grade and teacher's name. | |
| | | Has the teacher expressed concerns? | |
| | | Is your child experiencing academic difficulty? | |
| | | Does the child receive special services? | |
| | | Has an IEP been developed? Please provide a copy. | |

SOCIAL INFORMATION

YES NO

| YES | NO | When presented with the opportunity, my child..... |
|-----|----|---|
| | | verbalizes greetings and farewells. |
| | | asks questions |
| | | indicates when he/she does not understand |
| | | is able to follow directions |
| | | answers questions with adequate information. |
| | | clarifies responses willingly when necessary. |
| | | is comfortable being messy/dirty. |
| | | memorizes jingles or videos. |
| | | watches more than 1 hour of video, TV, or computer a day |
| | | echoes phrases (ie: repeats what is said to her/him) |
| | | enjoys reading independently |
| | | enjoys listening to books |
| | | enjoys repetitive activities (ie: does same activity over and over) |
| | | indicates refusal or objections appropriately. |
| | | converses well with adults |
| | | talks and plays with other children (outside of family). |
| | | has play dates |
| | | shares and takes turns. |
| | | has good relationship with his/her siblings. |
| | | tells me about activities or incidents that happen when he/she is not with you. |
| | | has a regular bedtime and wake up time. |
| | | responds appropriately to house rule and discipline. |
| | | has routine jobs/responsibilities around the house. |
| | | struggles with tooth brushing. |
| | | is a picky eater. |

Please describe your child's routine and their favorite past time.

Please circle any areas that may describe your child:

- | | | | | | |
|----------|-------------|------------|----------|--------------|-------------|
| Clumsy | Agile | Risk Taker | Cautious | Affectionate | Distant |
| Quiet | Loud | Confident | Shy | Passive | Aggressive |
| Outgoing | Plays alone | Stubborn | Friendly | Impulsive | Picky Eater |

Please list any additional comments about your child that you feel we should know:
