

Consent for Treatment/Insurance Reimbursement/Exchange of Information

Client Name:	Date of Birth:
SSN:	
Insurance Carrier:	
Name of Insured (if other than child):	Date of Birth:
Policy Number:	
Primary Doctor:	
therapy services for my child and permission to and other confidential information, as necessary carrier regarding health-related services that will also attest that I have been informed of the clin I understand that if insurance payments are made responsible for paying that amount to Chit Chat insurance does not cover the services, then I will child is covered under BabyNet and is under age I am aware that gross motor play is often encou	nic privacy statement. Copy available upon request. de directly to me, the insured parent, then I will be as payment for services. I also understand that if I be responsible for total payment of services, unless my a 3 and services will be covered through BabyNet. raged during therapy. Use of swinging, running, climbing, performance components the therapist may need to by and exempt my child's therapist and other
l give permission for Chit Chat Therapy to receive and exc information with the following: (Please check and fill in a	
o Pediatrician/Physicians:	
o Family Members:	
 School Teachers/District Officials: 	
o Early Interventionist:	
o Other:	
Attendance/Drop-off Policy ✓ I have read and agree to abide by the Attendan	ce/Drop-off Policy.
Financial Responsibility	
	n 30 days may be subject to a 10% late fee. In the event lance over 90 days, I agree to pay any and all additional sand that all insurance plans are different, and it is each plan and/or if my plan will reimburse for services to beginning therapy, however in many cases a true we been billed and an EOB is received. I understand that I served. If insurance denies therapy or applies charges to a
Signature of Parent/Guardian	 Date



Identifying and Family Information		
Child's Name:	Birth date:	Sex: M F
Mother's Name:	Phone:	
Address:	⊏πριογει	
Father's Name:	Phone:	
Address:	Employer:	
ALL CONTRACTOR OF THE CONTRACT	E-mail:	
Insurance Name and ID#:		
Primary Physician:		
Child lives with (check one):		
□Birth Parents □Foster		ne Parent
□Adoptive Parents □Parent	t and Step-Parent □O	ther
Other children in the family:		
Name Age Sex Grade	Speech/Hearing/Developr	nental Problems
Child's race/ethnic group:		
□Caucasian □Non-Hispanic	□Hispanic □Africar	n-American
□Native American □Asian or F		44
Primary Language Spoken in the I	Home:	
Any other languages spoken in the h	iome:	
Diagram tall are very marin concerns we		المحمد محاميدة والمانطة
Please tell us your main concerns re	garding todays visit and your c	ma s development.
		•
Do you feel your child has problems	with speech, fine/gross motor	control. and/or
sensory awareness? If yes, please of		
Do you feel your child has a hearing	problem? If yes, please descri	be.
According to the second		

Has he/she ever had a s where and when?	peech, physical, or	occupational evaluation/screening? If yes,
Has he/she ever had a h	earing evaluation/s	creening? If yes, where and when?
Has your child ever had swhen?		r occupational therapy? If yes, where and
What was he/she working	g on?	
Birth History Was there anything unus	ual about the pregr	nancy or birth? If yes, please describe.
How old was the mother Was the mother sick duri		
How many months or we Did the child have to stay reason? If so, please exp	in the NICU or hav	ancy? ve an extended hospital stay for any
Medical History Has your child had any o	f the following?	
□ adenoidectomy	□ encephalitis	□ seizures
□ allergies	□ flu	□ sinusitis
□ breathing difficulties	□ head injury	□ sleeping difficulties
□ chicken pox	□ high fevers	□ thumb/finger sucking habit
□ frequent colds	□ measles	□ tonsillectomy
□ ear infections How often?	□ meningitis □ mumps	□ tonsillitis □vision problems
□ ear tubes	□ mamps □ scarlet fever	uvision problems
Other serious injury/surge	ery:	

r

Is your child currently (or recently) under a physician's	care? If yes, why?
Please list any medications your child takes regularly:	
Developmental History	
put two words together	grasped crayon/pencil said first words
Does your child Yes □ No □ choke on food or liquids? Yes □ No □ currently put toys/objects in his/her mout Yes □ No □ brush his/her teeth and/or allow brushing	
Does your child Yes □ No □ repeat sounds, words or phrases over are Yes □ No □ understand what you are saying? Yes □ No □ retrieve/point to common objects upon receives □ No □ follow simple directions ("Shut the door" of Yes □ No □ respond correctly to yes/no questions? Yes □ No □ respond correctly to who/what/where/who	equest (ball, cup, shoe)? or "Get your shoes")?
Your child currently communicates using □ body language. □ sounds (vowels, grunting). □ words (shoe, doggy, up). □ 2 to 4 word sentences. □ sentences longer than four words. □ other	
Parent/Caregiver Signature	Date



2024 Attendance and Drop-Off Policy

Attendance:

Consistent therapy attendance is required by Chit Chat Therapy and is critical for your child's success. We realize that children do get sudden illnesses and emergency situations do occur. Our attendance policy allows for **2 missed visits (without 24 hour notice) within a six month period** to accommodate those situations. Early notification of a cancellation allows us to provide services to other children waiting to be seen for therapy and also allows us a better opportunity to reschedule your child to another time during the week to make up for the missed visit. We understand that there will be times when you have scheduled family vacation time and holiday festivities. In the event of a vacation/holiday we ask to have at least a one week notice so that we may try to find a time to reschedule your appointment or offer that time to another family wanting a makeup session. Calling the day before or the day of your appointment does not give us adequate planning time to try and make arrangements to see your child on a different time/day.

If your child accrues 3 or more last minute or no-show cancellations, the therapist may have to remove your child from a permanent spot on their caseload and/or discharge from therapy services. Therapists are paid on a per client/per week basis and cancellations in therapy directly affect their weekly income.

Most importantly, your child's progression in therapy is very important to us and without consistent attendance the rate of improvement is much, much slower. If your child's insurance requires authorization, then they will also be looking at the attendance and cancelations that show on the quarterly progress summaries we send them. Most of those companies will deny therapy is attendance is below 80% without justifiable causes.

Drop-Off:

We understand that your time is valuable and that there will be times in which you would like to drop your child off for therapy in order to run errands and maximize your time. However, we ask that you be available **5-10 minutes prior to the end of your child's therapy session** so that the therapist may talk with you and educate you on any home planning and discuss the events in therapy for that day and so that the therapist is ready and available for their next appointment. We also request that you always leave an emergency contact or cell number so you may be contacted in the event you are needed immediately for your child.

Thank you in advance for your support and understanding in these important matters.

Sincerely,

Chit Chat Staff