



# STONE OAK THERAPY SERVICES & LEARNING INSTITUTE

1020 Central Parkway South, San Antonio, TX 78232 Phone (210) 798-CARE (2273) Fax (210) 495-1479  
 Email address [2home@stoneoaktherapy.com](mailto:2home@stoneoaktherapy.com) Website [www.stoneoaktherapy.com](http://www.stoneoaktherapy.com)

## STONE OAK THERAPY SERVICES & LEARNING INSTITUTE Patient & Insurance Information Sheet

**Dear Parent,**

We are pleased that you are considering our center for your child's services. In order to provide the best care possible and to expedite scheduling your child's initial appointment with us, please use this check list to track the documents you need to sign and return to us.

- Patient-Parent Handbook
- Patient & Insurance Information
- Consent for Release of Information
- Terms of Service and Payment Agreement (Insured Pay & Private Pay)
- Signature to verify Receipt of HIPAA Privacy Notice, Our Privacy Practices
- Medical-Social History
- Additional information such as reports from consultations or assessments provided by physicians, therapists and school district
- Release and Waiver of Liability Assumption of Risk and Indemnity Agreement

### PATIENT INFORMATION

<b>PATIENT NAME:</b>	<b>DOB:</b>
<b>SSN:</b>	<b>MALE      FEMALE</b>
<b>ADDRESS: CITY AND ZIP</b>	<b>HOME PHONE: (    )      -</b>
<b>EMAIL ADDRESS:</b>	<b>WORK PHONE: (    )      -</b>
<b>PARENT OR GUARDIAN:</b>	<b>ALTERNATE PHONE: (    )      -</b>
<b>EMERGENCY CONTACT:</b>	<b>EMERGENCY CONTACT PHONE:</b>
<b>RELATIONSHIP TO PATIENT:</b>	<b>(    )      -</b>

### INSURANCE INFORMATION

<b>PRIMARY INSURANCE:</b>	<b>POLICY NUMBER:</b>
<b>POLICY HOLDER:</b>	<b>GROUP NUMBER:</b>
<b>INSURANCE PHONE NUMBER:</b>	<b>SSN:</b>
<b>POLICY HOLDER D.O.B.</b>	<b>RELATIONSHIP:</b>
<b>EMPLOYER NAME:</b>	<b>EMPLOYER PHONE:</b>
<b>SECONDARY INSURANCE:</b>	<b>POLICY NUMBER:</b>
<b>POLICY HOLDER:</b>	<b>GROUP NUMBER:</b>
<b>INSURANCE PHONE NUMBER:</b>	<b>SSN:</b>
<b>POLICY HOLDER D.O.B.</b>	<b>RELATIONSHIP:</b>
<b>EMPLOYER NAME:</b>	<b>EMPLOYER PHONE:</b>

### PRIMARY CARE PHYSICIAN INFORMATION

<b>NAME OF PRIMARY CARE PHYSICIAN:</b>	<b>OFFICE PHONE: (    )      -</b>
<b>ADDRESS:</b>	<b>OFFICE FAX: (    )      -</b>



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## CONSENT TO TREATMENT AND RELEASE OF INFORMATION

I authorize the staff of Stone Oak Therapy Services to:

1. Administer and perform those treatments that have been prescribed by my or by my child's physician.
2. Release pertinent medical information to my/my child's physician, referring agency, or insurer and others as may be required.
3. Request and obtain medical information from my/my child's physician and other health care professionals as necessary to provide quality therapy services.

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Printed Name of Patient

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Printed Name of Responsible Party

Relationship to Patient

---

Signature of Responsible Party

Date

## Terms of Service and Payment Agreement

### INSURED PATIENT:

I authorize Stone Oak Therapy Services to submit claims for services rendered to my insurance carrier or third party payer, and I request payment for these services be made directly to Stone Oak Therapy Services or its designee.

I understand that some services may not be covered by my insurance plan, or may be reimbursed at a much lower rate than what is usual and customary for this area. I further understand that I am responsible for any and all charges for services rendered that are not paid by my insurance carrier. This includes any fees incurred by Stone Oak Therapy Services in the event that my account must be forwarded to a collection agency due to non-payment.

### **ALL REQUIRED PAYMENTS ARE DUE AT THE TIME OF SERVICE.**

Full payment at the time of service will be required. If Stone Oak Therapy Services is unable to bill my carrier directly, an invoice will be provided for me to submit to my carrier for reimbursement.

### PRIVATE PAY PATIENT:

I accept responsibility for any and all charges for services provided to me/my child by Stone Oak Therapy Services. This includes any fees incurred by Stone Oak Therapy Services in the event that my account must be forwarded to a collection agency due to non-payment.

Full payment is due at the time of service/as indicated on statements sent to me by Stone Oak Therapy Services. My account will be considered delinquent if payment is not received within ten days of the payment due date listed on my statement. I understand that therapy services may be discontinued if my account becomes delinquent.

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Parent Signature

Date



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## PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the Stone Oak Therapy Services and Learning Institute's **NOTICE OF PRIVACY PRACTICES**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal or my child's personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Parent or Guardian of Patient                      Date                      Relationship to Patient  
Printed Name: \_\_\_\_\_

IF PARENT OR GUARDIAN OF PATIENT REFUSES TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW.

( ) Parent or Guardian of Patient refused to sign this Acknowledgement.

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Employee Printed Name and Signature: \_\_\_\_\_

## RELEASE AND WAIVER OF LIABILITY ASSUMPTION OF RISK AND INDEMNITY AGREEMENT

In consideration of me or my child receiving services at Stone Oak Therapy Services and Learning Institute, the undersigned (representing all parties affiliated with the patient and/or student), in full recognition and appreciation of the dangers and risks inherent in such therapeutic activities associated with helping children with cognitive and/or physically disabilities, do hereby waive, release, and forever discharge Stone Oak Therapy Services and Learning Institute, its parent and affiliate organizations, its officers, agents and employees from and against all claims, demands, action or causes of action for costs, expenses or damages to personal property or personal injury, or death which may result from such participation in these activities.

The undersigned also acknowledges that injuries received may be compounded or increased by negligent rescue operations or procedures. This waiver of liability extends to any rescue operations performed by the staff on the premises or on route to an emergency medical facility.

The undersigned affirms that all health information pertaining to the patient and/or student has been divulged prior to services being rendered. The undersigned acknowledges that s/he retains general medical/health insurance to cover any such accidents in the event they do occur.

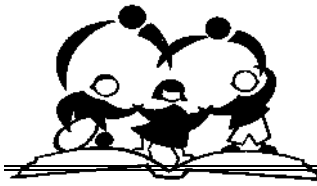
This waiver is intended to be as broad and inclusive as is permitted by law and that if any portion is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

I have read this release and waiver of liability, assumption or risk and indemnity agreement, fully understand its terms, understand that I have given up substantial rights by signing it, and have signed it freely and voluntarily without any inducement, assurance, or guarantee being made to me and intend my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

\_\_\_\_\_  
Patient or Student's Name

\_\_\_\_\_  
Parent's Name

\_\_\_\_\_  
Date



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## MEDICAL & SOCIAL HISTORY (BIRTH TO ONE YEAR)

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**PREGNANCY/BIRTH HISTORY**  
 Any problems during pregnancy or at birth (Measles, falls, anoxia, etc.) \_\_\_\_\_  
 \_\_\_\_\_  
 Place of Birth: \_\_\_\_\_  
 Delivery: Full Term \_\_\_ Premature \_\_\_ Prolonged \_\_\_ Forceps \_\_\_ Other \_\_\_\_\_  
 If Premature, at what gestational age was child born: \_\_\_\_\_ Birth Weight \_\_\_\_\_ Birth Height \_\_\_\_\_

**FAMILY DYNAMICS:**  
 Child lives with: \_\_\_ Both Parents \_\_\_ Father \_\_\_ Mother \_\_\_ Other (Explain): \_\_\_\_\_  
 Parents are: \_\_\_ Married \_\_\_ Divorced \_\_\_ Separated  
 \_\_\_\_\_  
 Father/Stepfather-please underline Age Years of School Completed Occupation  
 \_\_\_\_\_  
 Mother/Stepmother-please underline Age Years of School Completed Occupation  
 \_\_\_\_\_

Brothers/Sisters Stepbrothers/Stepsisters	Sex	Age	School	Grade or Occupation	Living in Home Yes or No

Other persons residing in the home (grandparents, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_

**EVALUATIONS OR TESTS PERFORMED (ST, OT, PT, Neurological, MRI, X-Rays, Behavioral, Psychological, at school or in the community etc.) List Evaluations or Tests Performed as follows:**

Type of Evaluations or Test Performed	Date	Where	Name of Provider	Address/Phone	Written Report Received

**PREVIOUS THERAPY SERVICES (ST, OT, ST, Behavioral Support at school or in the community):  
 List Previous Outpatient Therapists as follows:**

Services	Date Initiated	Length of Service	Name of Provider	Address/Phone	Frequency

**CURRENT THERAPY SERVICES (PT, OT, ST, Behavioral Support, at school or in the community):  
List Current Outpatient Therapists as follows:**

Services	Date Initiated	Length of Service	Name of Provider	Address/Phone	Frequency

**INFANT AND TODDLER DEVELOPMENT**

Please describe the age at which your child mastered the following activities: Please use Months.

	Months	Comments
Cooing		
Babbling		
First Words		
Two-Word Combinations (i.e. mommy, bye-bye, milk gone)		
Rolling Over:		
Sitting Alone		
Crawling		
Pulling Up to Stand		
Walking		
Running		
Throwing overhand		
Picking Up Small Objects with Hands (Cheerios, Raisins)		
Pass toys from one hand to another or play with a toy using both hands		
Drink from an open cup with minimum spillage		
Hold a spoon/fork to self feed with minimum mess		
Feed himself/herself		

**MEDICAL HISTORY**

**HEALTH SCREENING & EARLY DEVELOPMENT**

Has your child had problems with any of the following? (Yes or No) If yes, please explain.

Vision (wears glasses, etc.) \_\_\_\_\_

Hearing (hearing aides, etc.) \_\_\_\_\_

What is the date of most recent Vision and Hearing Screening? \_\_\_\_\_ Vision \_\_\_\_\_ Hearing \_\_\_\_\_

Speech \_\_\_\_\_ Coordination \_\_\_\_\_

(running, throwing, writing, etc.) \_\_\_\_\_

Serious illnesses (Complications with childhood illnesses, high fever, etc.) \_\_\_\_\_

If your Child has never had a formal Vision and Hearing Test, would you or your physician attest to your child's vision and hearing skills to be functional and adequate for developmental testing (Speech, PT, OT, etc.)? \_\_\_\_\_

Has your child participated in an Early Childhood Intervention Program? \_\_\_\_ If yes, please describe services received, provider, and length of service: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL HISTORY**

Are immunizations up to date? \_\_\_\_\_ If not, what immunizations are missing? \_\_\_\_\_  
 Does your child receive annual flu vaccines? \_\_\_\_\_ List dates received: \_\_\_\_\_  
 Hospitalizations (accidents, etc.) \_\_\_\_\_

Surgeries: \_\_\_\_\_

Current Medications (type, purpose): \_\_\_\_\_

Date of most recent physical: \_\_\_\_\_ Physician: \_\_\_\_\_

Check the appropriate items that apply to your child's' health condition(s) and childhood illnesses.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Heart trouble                      | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Joint pains                        | <input type="checkbox"/> Chicken pox     |
| <input type="checkbox"/> Chest pains             | <input type="checkbox"/> Reaction to drugs                  | <input type="checkbox"/> Diphtheria      |
| <input type="checkbox"/> Colds (frequent/severe) | <input type="checkbox"/> Skin rashes or eczema              | <input type="checkbox"/> Measles         |
| <input type="checkbox"/> Convulsions or seizures | <input type="checkbox"/> Stomach disorder or abdominal pain | <input type="checkbox"/> Mumps           |
| <input type="checkbox"/> Ear trouble             | <input type="checkbox"/> Tumor or growth                    | <input type="checkbox"/> Pneumonia       |
| <input type="checkbox"/> Frequent sore throats   | <input type="checkbox"/> Urinary infection                  | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Headaches (frequent)    | <input type="checkbox"/> Minor/Major Head Injury            |  |
| <input type="checkbox"/> Other: _____            |   |  |

Please explain any areas checked above: \_\_\_\_\_

Diagnosis (describe each and when diagnosed): \_\_\_\_\_

**Please complete the following.**

<b>Please check the following that best describes your child by using the scale at the right. Does your child exhibit the following behaviors:</b>	<b>Always</b>	<b>Most of The Time</b>	<b>Sometimes</b>	<b>Not Frequently</b>	<b>Never</b>
<b>Movement</b>					
In constant motion, rocking, running about, unable to sit still for an activity					
Absent or brief crawling before walking (over 1 year)					
Distressed by being swung in air, swings, merry-go-rounds, car rides					
Craves swinging and moving upside down					
Clumsy, falling, poor balance, bumps into things (over 1 year)					
Fearful or hesitancy moving over changing surfaces (e.g. sidewalk to grass, carpet to wood floor)					
Dislikes laying on back					
Distressed by common sounds (e.g. music, singing, vacuuming, flushing toilet, raised voices)					
Doesn't respond to verbal cues (hearing not a problem, over 1 year)					
None or very little vocalizing or babbling					
Distracted by sounds not normally noticed by average person (e.g. furnace, refrigerator)					

**In your own words, please describe the primary concerns you have about your child's development and the goals you wish to accomplish by seeking services at our center:**
