Dear Parents:

Thank you for choosing Mobile Therapy Centers of America, LLC (MTC) for your child's behavioral therapy needs. At MTC, we strive to provide the highest quality of therapeutic intervention. Our services are provided in safe and convenient settings, which facilitate the overall progress and development of your child. We also recognize the importance of a team approach to therapy by incorporating your family's input as well as all of the professionals working with your child.

We have assembled an enrollment packet that includes information for your review as well as information to be completed and returned to MTC prior to the onset of an evaluation and/or therapy. Your timely completion of this packet, affords familiarity with our policies and services, and provides critical information to the therapists working with your child.

Please contact us if you have any questions or need assistance in completing the forms. Once completed, please fax or email the enrollment packet to the MTC office at 847-816-7210, enrollment@mtcus.com or leave it in your childcare center's MTC mailbox.

We appreciate the opportunity to work with your child and look forward to getting to know your family.

Sincerely,

Nicole Brachfeld M.A. CCC-SLP/L

Nicole Brachfeld M.A. CCC-SLP/L
Director of Therapy
Mobile Therapy Centers of America, LLC

CHILD HISTORY FORM

Date: _______________

Child's Name: ___________________________ Birth Date: _____________ ☐ Male ☐ Female

Parents/Legal Guardian: ______________________________ Home Phone: _________________

Parents: ☐Married ☐Divorced ☐Separated

Primary Insured/Responsible Party: _____________________________

Address: ________________________________ City: _________________________ Zip: ________________

Best way to contact you: ☐home ☐work / cell ☐email Home Phone: _______________________

Cell Phone (dad): __________________________ Cell Phone (mom): ________________________________

Work Phone (dad): _________________________ Work Phone (mom): _______________________________

May we leave a voicemail: ☐Yes ☐ No May we leave a voicemail: ☐Yes ☐ No

Email Address: ___________________________ May we send you emails at this address: ☐Yes ☐No

Medical Diagnosis: Yes No If yes, please explain: ____

____

Pediatrician/Family Doctor Information:

Name: _____________________________________ Phone: _________________ Fax: ___________________

Child's Medical History:

☐ Full term pregnancy ☐ Premature Birth ☐ No pregnancy or birth complications

Newborn hearing screening results: ☐ Pass ☐ Fail

Complications or health problems after birth: ☐ Yes ☐ No

If yes please explain: ____

Ear Infections: ☐ Yes ☐ No

If yes, please describe frequency and treatment: ____

Reflux: ☐ Yes ☐ No

If yes, please describe frequency and treatment: ____

Allergies: ☐ Yes ☐ No

If yes, please describe frequency and treatment: ____

Seizures: ☐ Yes ☐ No

If yes, please describe frequency and treatment: ____

General developmental milestones:

Speech

Did your child babble by: 3-6 months ☐ Yes ☐ No

Did your child say their first words by: 9-12 months ☐ Yes ☐ No

Did your child combine words by: 18-24 months ☐ Yes ☐ No

While reading a book can your child point to named objects: ☐ Yes ☐ No

Please describe your concerns: ____

Social Play

Does your child: ☐ play well with and/or near others ☐ plays with toys in different ways than intended

☐ Have difficulties when there are changes in routines ☐ show interest in other children

☐ Have tantrums for longer than ten minutes

Please describe your concerns: ____

Gross Motor

Did your child roll by: 5-7 months ☐ Yes ☐ No

Did your child sit without support by: 6-8 months ☐Yes ☐ No

Did your child crawl by: 9-11 months ☐ Yes ☐ No

Did your child walk alone by: 12-15 months ☐ Yes ☐ No

Does your child fall or lose balance easily: ☐ Yes ☐ No

Please describe your concerns: ____

Fine Motor & Sensory Processing

Has your child established a hand preference: ☐ Yes ☐ No

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p. 847-816-7200 *f.* 847-816-7210

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Does your child have negative reactions to:

☐ Touch ☐ Loud Noises ☐ Face washing ☐ Wet messy play ☐ Swinging

Please describe your concerns:____

Feeding & Growth

Is your child losing weight or have poor growth: ☐ Yes ☐ No

Does your child:

☐ Try new foods ☐ Gag easily when eating ☐ Vomit frequently ☐ Refuse foods

Do meals take longer than 30 minutes: ☐ Yes ☐ No

Please describe your concerns: ____

Therapy services

Current or past evaluations or therapies received: ☐ Yes ☐ No

If yes, please list (type, date and facility): ____

____

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Treatment Consent/Responsible Party Statement

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility.

Responsible Party Signature Date

I hereby assign and authorize payment of all medical benefits to which I am entitled to Mobile Therapy Centers of America, LLC (MTC) in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is, therefore, in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of the debt. This includes, but is not limited to, collection service fees, attorney's fees and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (18% annually) for unpaid balances over thirty days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of MTC as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Authorized Signature Date

Billing Policy

Included Services:
Your child's comprehensive services include: daily written, therapeutic updates on your child's treatment, updates with his/her classroom teacher(s) informing them on your child's current goals/session progress, a quarterly three month progress report updating your child's short term goals and long term progress to date and 5 minutes of consultation (email, phone, in person) for every hour of direct service.

Additional Charges:
A quarterly consultation charge (once every three months) of $75 will be billed to your insurance.

Attendance at parent/teacher conferences, child specific planning and/or staff meetings and therapy sessions conducted in your home are available at an additional charge and can be arranged by calling the MTC office.

Authorized Signature Date

PATIENT PAYMENT CONSENT

I authorize Mobile Therapy Centers of America, LLC (MTC) to keep my signature on file and to charge the credit card listed below for:

- Patient statements are generated on the 5th of each month. Outstanding patient balances will be charged monthly to the credit card on file on the 20th of each month.

I agree to contact MTC promptly if the credit card listed below expires or is terminated prior to completion of payment of my balance.

MTC will not begin services until credit card information is on file.

(ATTACH COPY OF CREDIT CARD)

☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Authorization of Cardholder Signature ____

Billing Address ____

Date ____

Card Holders Name (as it appears on the card) ______________________________________

Account # ____

Three digit security code on back of card ______________________

Expiration Date _____________________________

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ENROLLMENT AGREEMENT

Attendance
In order for your child to receive the maximum benefits of therapy, consistent attendance is essential. To maintain your child's therapy time slot, we require an 80% compliance rate. Please provide 24-hour notice for all cancellations. Cancellations with less than 24-hour notice and "no shows" will incur a $50 charge due at the time of your child's next appointment. Exceptions to this policy include cancellations as a result of infectious illness or emergency. Two "no shows" or frequent cancellations may cause you to lose your scheduled therapy time slot. In the event that a therapy session is cancelled, we will make every attempt to reschedule your child's appointment.

____
Please Initial

Photography/ Videotaping
______________________(your child's name) can/cannot (circle one) be video-taped/photographed while receiving therapy by MTC. Videotapes/photographs may be used for therapist instruction, marketing/promotional materials, and therapist review. Parents will be notified if pictures will be used for marketing purposes for MTC.

____
Please Initial

Change of Information
Parents/caregivers are responsible for informing MTC of any changes in address, insurance, telephone number, etc. in a timely manner.

____
Please Initial

Insurance Verification
MTC offers insurance verification as a complimentary service; however, this process does not guarantee coverage. We recommend that parents/caregivers review their benefit status on a regular basis.

____
Please Initial

Release to Exchange Information
In order to ensure the best possible therapy, MTC may exchange information regarding your child's therapy sessions with the appropriate childcare/school personnel.

____
Please Initial

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Payment

MTC requires a credit card number to be kept on file. Outstanding patient balances will be charged monthly to the credit card on file.

____
Please Initial

Billing of Insurance

MTC will make every attempt to bill and collect payment from the insurance company based on the information provided at the time of intake. However, this does not guarantee payment by your insurance company. As a courtesy on your behalf, MTC will re-submit the claim after a second denial or receipt of partial payment from your insurance provider. MTC will require that all balances be paid in full.

____
Please Initial

Freedom of Choice

MTC has informed your family of your freedom of choice to choose amongst other providers for the recommended services, such as calling early intervention (800) 323-4769, calling your insurance carrier for a list of providers, and contacting your local school district.

____
Please Initial

Email Communication

Your child's daily treatment notes and three month progress reports will be transmitted via email. If official copies of these documents are needed, please contact the MTC office with your request and a signed copy will be mailed to you.

____
Please Initial

Mobile Therapy Centers of America, LLC (MTC)

Notice of Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION.

Mobile Therapy Centers of America's Legal Duty

Mobile Therapy Centers of America, LLC (MTC) is required by the Health Insurance Portability Accountability Act of 1996 (HIPAA) to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

Uses And Disclosures Of Health Information

MTC uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care we provide. For example, MTC may use your personal health information to contact you to provide appointment reminders, to provide information about treatment alternatives, or any other health related benefits that could be of interest to you.

MTC may also use or disclose your personal health information without prior authorization to your child's childcare staff and administration, public health purposes, auditing purposes, or for emergencies. We may provide de-identified information for research studies. We also provide information when required by law.

In any other situation, MTC will obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

MTC may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of the clinic, designated child care center, or otherwise provided to you. You may also request an updated copy of our Notice of Patient Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency situations. MTC will consider all such requests on a case-by case basis, but are not legally required to accept them.

MTC PATIENT INFORMATION CONSENT FORM

I have read and fully understand the MTC Notice of Patient Information Practices. I understand that MTC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify MTC in writing. I also understand that MTC will consider requests for restriction on a case-by-case basis, but does not have to agree to requests or restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in the MTC Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying MTC in writing at any time.

____
Patient Name

________________________________ ____________________
Signature of Legal Guardian Date

CHILD EMERGENCY FORM

Child's Name: ________________________________

Parent(s)/Legal Guardian's Name: ____

Home Phone: ______________________________ **Cell Phone:** ______________________________

In case of an emergency and you cannot be reached, please provide the names and phone numbers of at least two people who can be contacted and who your child can be released to. Any changes must be made in writing.

Name	Relationship	Address	Home Phone	Cell Phone

- **Allergies or Important medical information:** ____

____

____

____

______________________________ ________________________

Parent Signature **Date**