



Dear Parents:

Thank you for choosing Mobile Therapy Centers of America, LLC (MTC) for your child's 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,

A handwritten signature in black ink that reads "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

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): _____



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 and a quarterly three month progress report updating your child's short term goals and long term progress to date.

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, are available at an additional charge and can be arranged by calling the MTC office.

Authorized Signature

Date

1870 W. Winchester Road Suite 203 Libertyville, IL 60048
p. 847-816-7200 f. 847-816-7210



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 _____



ENROLLMENT AGREEMENT

Doctor's Orders/Prescription

In order to treat your child, we will need a current Doctor's prescription. Without this order, services are not available. Families are also responsible for assisting Mobile Therapy Centers of America, LLC (MTC) with updating therapy prescriptions. Any time there is a change in your child's medical/health status (e.g. hospitalization, surgery, etc.); a new prescription is needed in order to continue therapy services.

Please Initial

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

Treatment

I agree and understand that my child will be provided one-on-one/co-treatment therapy by an MTC licensed and credentialed therapist(s) in a location designated by my school/childcare facility. All MTC therapists meet the NAEYC guidelines for providing services in a childcare center. Including being licensed by the state of Illinois and credentialed by their governing organization, they have completed background checks and are fingerprinted and have completed CPR/ First Aid Certification.

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

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 and 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 center 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