6927 Old Seward Hwy. STE. 100
Anchorage, AK 99518
907-345-0050 Phone 907-344-5103 Fax

Child's Name: _____

Date of Birth: _____

NEW PATIENT INTAKE FORM

PERSONAL INFORMATION

Child's Legal Name: _____ Date of Birth: _____

Age: _____ Male: _____ Female: _____

Mother or Legal Guardian: _____ **Father or Legal Guardian**: _____

DOB: _____ DOB: _____

Please check if it is ok to leave a message	Yes	No		Yes	No
Home Ph.: _____	☐	☐	Home Ph.: _____	☐	☐
Cell Ph.: _____	☐	☐	Cell Ph.: _____	☐	☐
Work Ph.: _____	☐	☐	Work Ph.: _____	☐	☐

Best number to reach you at: _____

Physical Address: _____ Physical Address: _____

_____ _____

Mailing Address: _____ Mailing Address: _____

_____ _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Who referred you to our office? _____

Child resides with? _____

Who has custody of the child? _____

If primary person bringing child to therapy is not listed above, please list name and contact phone number of that person. _____

EMERGENCY CONTACT: _____
NAME: _____ **PHONE:** _____
RELATIONSHIP:

<u>INSURANCE INFORMATION</u> (please fill out ALL areas)

Primary Insurance: _____ Secondary Insurance: _____

Policy Number: _____ Policy Number: _____

Group Number: _____ Group Number: _____

Claims Address: _____ Claims Address: _____

_____ _____

Phone Number: _____ Phone Number: _____

Insured's Name: _____ Insured's Name: _____

Insured's DOB: _____ Insured's DOB: _____

I <u>DO NOT</u> YOU HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAT THE ABOVE MENTIONED. Initial _____

6927 Old Seward Hwy. STE. 100
Anchorage, AK 99518
907-345-0050 Phone 907-344-5103 Fax

Child's Name: _____

Date of Birth: _____

Emergency Medical Release
In the event medical attention is required for your child while the premises of AFKPT, LLC, we need your authorization to implement treatment. Please read and sign statement below.

As legal guardian of _____, I give my permission for AFKPT, LLC to contact emergency personnel in the event of a medical emergency.
Parent/Legal Guardian Signature _____Date_____

MEDICATION/ALLERGY/CONDITION FORM

Medication: Please include prescription drugs, over the counter medications, vitamins, and homeopathic medications.

_____

_____

Allergies/Reactions:

_____

_____

Diagnosis: Please indicate any medical diagnosis or medical condition, with dates if known.

_____

_____

PHOTO PERMISSION **Initial/Date**

1. I give permission for photographing/videotaping of my child for the purposes of treatment, education, and documentation. ___/___
2. I give permission for photographing/videotaping of my child to be used for advertising, brochure, and/or webspace. ___/___

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA):
I acknowledged that I have viewed, read, and understand the HIPAA Policy and have been informed of my rights as a patient's parent/guardian.

Signature: _____Date: _____

AUTHORIZATION AND CONSENT FOR TREATMENT, PAYMENT, AND OPERATIONS:
Please initial the following statements:
_____ I have a prescription from my child's physician to authorize initial evaluation.
_____ I have checked with my insurance company prior to this therapy visit and assert that I have obtained the necessary information regarding limits of coverage, co-pays, and co-insurance.
_____I hereby give All For Kids Pediatric Therapy, LLC permission to evaluate and treat my child, and I understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and All For Kids Pediatric Therapy, LLC staff. I understand that state representatives for the purpose of insurance certification or licensing and quality assurance may review my child's records. I understand that all practices of confidentiality will be followed in use of the information gathered.

_____ I give All For Kids Pediatric Therapy, LLC permission to submit bills directly to the insurance carrier.
_____ I have read and agree to follow All For Kids Pediatric Therapy, LLC's office and financial policies.

_____ _____
Signature of Parent/Guardian **Date**

6927 Old Seward Hwy. STE. 100
Anchorage, AK 99518
907-345-0050 Phone 907-344-5103 Fax

Child's Name: _____

Date of Birth: _____

Child's primary care physician**:** _____

List the names of the programs and people that have worked or are working with your child outside of All For Kids.

Service	Program Name	Teacher/Therapist	Phone #	Dates
Pediatrician/Physician				
Child Care Program				
Preschool				
School				
Occupational Therapist				
Speech Therapist				
Physical Therapist				
Counselor/Psychologist				
Infant Learning Program				
Head Start Program				
Caseworker/Care Coordinator				
Dietitian/Nutritionist				
Specialty Doctor				
Other				

I hereby authorize any prior or present treating physician, therapist, school, hospital, or other health institution, to release all of medical information by any means of communication to All For Kids Pediatric Therapy LLC.

_____ _____

Signature of Parent or Guardian **Date**

If your child has an IEP through his/her school, please bring us a copy for our records.

6927 Old Seward Hwy. STE. 100
Anchorage, AK 99518
907-345-0050 Phone 907-344-5103 Fax

Child's Name: _____

Date of Birth: _____

HISTORY FORM

Please answer the questions to the best of your ability and in as much detail as possible. Please add any information that you feel is important but is not covered on this form.

General History

1. Child's Name_____ DOB_____
2. Siblings' Names and Ages:_____
   _____
3. Living Situation (and any recent changes):_____
   _____
   _____
4. School History(Name of school, IEP, grade, etc):_____
   _____
   _____
5. Does your child have any medical diagnoses? Please list:_____
   _____
   _____
6. When did you first become concerned about your child's development?
   _____
   _____
   _____
7. Has your child received occupational, physical, or speech therapy in the past or is he/she currently receiving any of these services? (Please list providers and days/times if currently received)
   _____
   _____
   _____
8. Please indicate at what age each major milestone was reached:
   a. Sitting up by self_____ Crawling_____ Walking_____
   b. First word_____ What was their first word? _____

Medical History

1. Did the child's mother have any illnesses or complications during pregnancy or delivery? Please describe:_____
   _____
   _____
2. Was your child premature? Yes or No
3. Born at how many weeks gestation?_____ Birth Weight_____
4. Did your child require any medical procedures before, during, or after birth? Please describe:
   _____
   _____

FEEDING

5. Did your child have any feeding problems as an infant? Please describe:
   _____
   _____
6. Was your child bottle fed or breast fed and for how long? _____
7. Did your child have any colic or reflux issues? _____

6927 Old Seward Hwy. STE. 100
Anchorage, AK 99518
907-345-0050 Phone 907-344-5103 Fax

Child's Name: _____

Date of Birth: _____

HEARING

8. Have your child had any ear infections? (Please list number if known)_____
   _____
   _____

9. Has your child had their hearing tested? What were the results?
   _____
   _____

ILLNESSES

10. Does your child have any allergies? Please list:_____
    _____

11. Please describe illnesses, medical issues, or hospitalizations that your child has had and when they occurred.
    _____
    _____
    _____

OTHER

12. Does your child wear glasses or hearing aids? If yes, why?_____
    _____

13. If your child was adopted, please answer the following questions:
Age of adoption_____ Is your child aware of adoption? YES or NO
Previous home experiences prior to adoption: _____

Personal Information

1. Please describe your child's personality:

2. How do you handle discipline issues at home?

3. Does your child have tantrums? YES or NO
   a. How Often? _____

6927 Old Seward Hwy. STE. 100
Anchorage, AK 99518
907-345-0050 Phone 907-344-5103 Fax

Child's Name: _____

Date of Birth: _____

4. How does your child handle changes and variation in routine?

5. Please describe your child's eating habits and typical intake:

6. Please describe your child's sleeping habits/patterns:

7. Briefly describe a typical day for your family, especially this child:

6927 Old Seward Hwy. STE. 100
Anchorage, AK 99518
907-345-0050 Phone 907-344-5103 Fax

Child's Name: _____

Date of Birth: _____

PATIENT AGREEMENT

All For Kids Pediatric Therapy, LLC offers Physical Therapy, Occupational Therapy, and Speech-Language Pathology services for patients referred to our practice. We are a licensed provider who develops individualized treatment plans to identify the services that will best suit your child's therapy needs. We will also work with your primary care practitioner to coordinate your care.

Following the initial assessment visit(s), we develop a specific plan of care (POC) for review and approval by your child's referring provider. Once your child's referring provider signs the (POC), we can begin working with your family to improve your child's condition. We are pleased to serve your Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology needs and encourage your feedback to alert us to anything we can do to provide your child the highest quality of care.

We require certain information from each patient in order to begin providing care. The attached forms need to be completed in order for us to begin serving your child as our patient. Please do your best to complete all the information. If certain information does not apply to your child, please indicate that by noting "N/A" ("Not Applicable") so that we know that you did not overlook anything.

Each healthcare insurance payor has different guidelines for allowing coverage of Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services. It is helpful if you let us know your healthcare payor when starting service so that we may find out if prior authorizations are needed. If your child is a Medicaid beneficiary, please ask your primary care provider to send us a referral for your initial assessment to fulfill Medicaid requirements. If your healthcare insurance payor does not cover Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services, you are welcome to make self pay arrangements for the usual and customary pricing of our services.

ALASKA MEDICAID RECIPIENTS:

Alaska Medicaid requires that a physician, physician assistant, or advanced nurse practitioner refer you to our practice before we can perform an initial assessment on you. After we have completed your initial assessment, we develop an individualized POC to meet your specific therapy goals.

Your primary care practitioner will need to review and approve your POC, and then return it to our practice before we can begin your treatment.

6927 Old Seward Hwy. STE. 100
Anchorage, AK 99518
907-345-0050 Phone 907-344-5103 Fax

Child's Name: _____

Date of Birth: _____

MEDICAID & PRIVATE INSURANCE
CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICE

Private insurance companies may have limits on the amount of Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services covered. Once you have exceeded the financial limit of your benefits and you do not have additional healthcare coverage, you are responsible for the payment of your child's services. Additionally, private healthcare insurance payors have deductible and co-payments for physical therapy, occupational therapy, and/or speech language pathology services that are the responsibility of the patient.

While this practice will not discontinue your child's services for financial hardships, it is expected that patients pay at the time of service and/or set up payment arrangements.

COLLECTION OF PAST DUE ACCOUNTS

We communicate with our patients' parents/guardians to resolve past due accounts in all cases. If we cannot reach a patient's parent/guardian by phone following the return of undeliverable mail, or if a patient payment agreement cannot be made or paid as agreed, we are forced to use the services of a professional collection agency. Once an account is placed with a collection agency, we cannot take the account back. Please let us know when or if your patient contact information changes so that we can always reach you, if needed, to discuss past due accounts.

FINANCIAL AGREEMENT

New patients approved for Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services are responsible for any and all charges not paid for by healthcare insurance payors (Medicaid, private health insurance carriers, etc.). By signing this patient agreement, you are acknowledging that you understand this condition of service and commit to promptly paying All For Kids Pediatric Therapy for the services we provide to you, our valued customer. Following the receipt of your monthly patient statement, please contact our practice to make payment arrangements. We accept cash, personal checks, money orders, and credit cards (VISA, MasterCard, and Discover Card); we also make credit card pre-payment arrangements for anticipated monthly patient balances. We also are willing to make reasonable payment arrangements to keep your account current. Please contact our Billing Office at (907) 345-0050.

QUALITY ASSURANCE & COMPLAINT RESOLUTION

Should you or your child's caregiver experience a situation that requires the attention and resolution of a Supervisor and/or Manager, please contact our practice either in writing or by phone at (907) 345-0050. A member of our management team will interact with you to reach a resolution of any identified situation where our quality of service has been compromised. We use such situations to alert us to improvements we can make to better serve all our patients.

PATIENT STATEMENT OF AGREEMENT

My signature below signifies that I have read and understand this patient agreement for All For Kids Pediatric Therapy, LLC to provide me Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services. I agree to the terms in this patient agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.

_____ _____

Parent/Legal Guardian **Date**

_____

Relationship to Patient

6927 Old Seward Hwy. STE. 100
Anchorage, AK 99518
907-345-0050 Phone 907-344-5103 Fax

Child's Name: _____

Date of Birth: _____

FINANCIAL POLICY

Welcome to our office! We are committed to providing you with the best possible care. If you have medical insurance, we are willing to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

Payment, co-payment, deductibles, and co-insurance for services are due each visit for charges incurred up through your last visit. We accept cash, checks, VISA, MasterCard, and Discover Card. **Please understand that you are financially responsible for all charges, whether or not they are paid by insurance.**

Please read carefully:

1. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. As a courtesy to our patients, we will bill your insurance carrier; however, we cannot guarantee payment in a timely manner. If for any reason any portion of a bill is not paid by your insurance within 60 days from the date of service, you agree to make arrangements for prompt payment.

2. Should your insurance coverage change, our office should be notified within 30 days of the effective date and the card or stickers should be available for copying. If you fail to provide us this information, your account and all future balances will be your responsibility. We will no longer bill insurance and you will be responsible for submitting claims to your insurance. Payment will also be due at the time of service in full.

3. Our fees are generally considered to fall within the acceptable range by most insurance carriers and therefore are covered up to the maximum allowance determined by each carrier. This applies to the companies who pay a percentage (such as 50% or 80%) of the usual, customary, and reasonable rate (UCR). This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.

4. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility. **Please note insurance companies may indicate the services were not medically necessary and claim that, because All For Kids is a preferred provider, you do not have to pay the balance. This is NOT the case and you will be billed for the services.** This office cannot accept responsibility for negotiating settlements on disputed claims.

5. Any returned checks will be subject to a NSF fee of $25.00 which will be due at the next visit.

6. Accounts that are past due will incur a finance charge at the rate of 10.5% annually.

Again, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing department promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

I hereby understand the above financial policy and agree to abide by it.

_____ _____

Parent or Guardian Signature **Date**

6927 Old Seward Hwy. STE. 100
Anchorage, AK 99518
907-345-0050 Phone 907-344-5103 Fax

Child's Name: _____

Date of Birth: _____

CANCELLATION POLICY

Our clinic strives to provide the best therapy services possible. In order to ensure optimal use of valuable therapy time, **please discuss schedule changes at the end of your appointment with your therapist and the front desk administrator**. We understand occasional changes are necessary due to illness, vacations, etc. Please call our office within 24 hours of a scheduled appointment if you need to cancel or reschedule that appointment. This allows for clients to reschedule into additional openings therapists may have. For Monday morning appointments, our office appreciates being notified no later than Friday noontime. This will allow other patients in need of care to be accommodated as we have many patients. It is both unfair to the other patients and therapists to not allow for others to schedule in the open time slots.

- I understand it is my responsibility to communicate to the front desk. Any schedule changes or appointment cancellations.
  _____ initials

- If a session is delayed for more than 10 minutes due to late arrival of the client, the parent(s)/guardian will be charged a $10.00 late fee. **Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the parent(s)/guardian.
  _____ initials

- If a parent/guardian is more than 5 minutes late to pick their child up, the parent(s)/guardian will be charged $1 for every minute they are late. (e.g., You will be charged $6 on the 6th minute of being late, etc.) This is to ensure that parents are present so the therapist can collaborate with the parent(s)/guardian and other children's sessions can start on time. **Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the parent(s)/guardian.
  _____ initials

- If a therapy session is not cancelled prior to an appointment time or is missed without any notice, this missed appointment is counted as a no-show which will result in a charge of a $50.00 no-show fee. **Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the parent(s)/guardian.
  _____ initials

- Two consecutive no-shows may require your child to be placed on a hold status until the issue of missed appointments is resolved. If a resolution is not made within 5 business days, your child will lose his/her therapy time and be placed on our information list.
  ____ initials

- We require an 80% attendance rate and may need to remove the patient from the therapist's schedule if efforts are not made to maintain this rate. Note: We track visit frequently and, as a courtesy, will notify you if your percentage drops below the required 80%.
  _____ initials

We are happy to work out scheduling problems with you. Please let us know if you are experiencing a problem with your current schedule. If therapy needs to be canceled for a couple of weeks, (such as for an extended trip), we will hold your therapy spot for up to three weeks. We will then place you on the information list and will fit you back in the schedule as soon as we can.

I hereby understand the above cancellation policy and agree to abide by it.

_____ _____

Parent or Guardian Signature **Date**

6927 Old Seward Hwy. STE. 100
Anchorage, AK 99518
907-345-0050 Phone 907-344-5103 Fax

Child's Name: _____

Date of Birth: _____

Clinic Etiquette

Once again, we welcome you to All for Kids Pediatric Therapy. We are honored that you have chosen our clinic to meet the needs of your child and your family. We continually try to create a space and an atmosphere that is true to our name – fun and inviting for kids and their families. We hope that you are comfortable here and always feel welcome. Please know that you can approach us with any comments or concerns regarding our space and how it is used. In order to make All for Kids a comfortable and safe place for all of our families and our staff, we ask that families follow our clinic etiquette plan. Please read and become familiar with the following expectations.

1. Before entering treatment areas, we ask that you remove your children's shoes as well as your shoes. There is space near the front desk window to leave shoes as well as coats/jackets.
2. Before entering treatment areas without a therapist, please check in at the front desk to allow for patient confidentiality and compliance with HIPAA policies.
3. Closely monitor your children's behavior in the waiting room to ensure that they are playing safely and appropriately with other children. Please do not allow children to climb on, jump from, or disassemble the waiting room furniture or toys.
4. Please clean up after your children in the waiting room. Help them replace any books or toys they may have used and throw away any trash that may have accumulated.
5. Accompany all younger children and those needing assistance or supervision to the restroom; this includes using the restroom for hand washing.
6. If you have children in diapers or pull-ups, please bring a diaper bag to therapy and be prepared to change your child if necessary.
7. Do not allow your children to enter the treatment area unaccompanied.
8. For safety reasons, please do not allow your children to play with the doors in the waiting room.
9. The family is always invited to attend your child's treatment session. However, if siblings will be observing or participating, please do not allow them to play with equipment without obtaining permission from a therapist. Also, equipment may be used with permission as long as no other therapist needs to access that equipment. Plan to provide any siblings attending therapy with their own toys or activities.
10. We discourage bringing toys from home to treatment sessions unless your therapist requests them or gives permission to bring them. Your therapist will choose toys from our clinic with a specific therapeutic purpose.
11. If you are observing your child's treatment session, remain in the same room as your child and their therapist. In order to protect the confidentiality of all children in our clinic, we ask that if you need to leave the treatment room for any reason, you return to the waiting room and wait for the session to end. If your child and their therapist leave the room, either follow them or wait for them in the waiting room.
12. Please keep cell phone and tablet use to a minimum in treatment areas and place phones on vibrate or silent. Cell phone and tablet use is acceptable in the waiting room and other common areas, but please keep phone conversations brief and use headphones if watching videos or listening to music. Please take extended phone conversations outside the waiting room to the arctic entry.
13. Please be mindful of the content discussed in your conversations (phone or in-person) or viewed on your electronic devices. Please only discuss topics or select websites, videos, music, etc. which are appropriate to discuss/view in the presence of children.

6927 Old Seward Hwy. STE. 100
Anchorage, AK 99518
907-345-0050 Phone 907-344-5103 Fax

Child's Name: _____

Date of Birth: _____

14. Please do not ask therapists about other clients or families at the clinic. In order to comply with HIPAA, we cannot answer these questions.
15. Be respectful of the 'end of session' time. Your therapist typically has less than 5 minutes to talk to you about the session. In most cases, there is another family waiting to begin therapy. If you need additional time to discuss a concern, ask questions, or problem-solve treatment activities, please join your child's session or arrange for an alternative time to discuss those topics with your child's therapist.
16. Due to the number of children we treat with allergies and restricted diets, we ask that no outside food be taken beyond the waiting room. If your therapist needs to incorporate food into the treatment session, they may request that you bring specific foods to your session. Please also clean up any food messes that occur as quickly as possible to avoid accidental ingestion by other clients.
17. Please make arrangements to attend your child's therapy session when requested by the therapist. Having active parent participation in the therapy process is critical for learning/progress in skills and carryover of these skills to environments outside the therapy room. Additionally, we welcome parent requests to join treatment sessions. Please let your child's therapist know if you would like to participate in a session.

As your team of therapists, you can expect us to:

1. Begin and end your appointments in a timely manner.
2. Inform you of the goals targeted and the progress made during each session.
3. Provide strategies and ways for you to address goals at home to increase carryover.
4. Assist you in any way we can, from brainstorming ideas to help make your families' lives easier at home to talking with school therapists, etc.
5. Keep anything you share with us confidential.
6. Provide the best therapy we possibly can.
7. Write the therapist's name on the treatment door so that you can easily locate your child, if needed.
8. Receive courteous and friendly help when scheduling appointments or dealing with billing questions.

If you have any questions about the above information, please don't hesitate to ask us.
We are here to help you!

I have read and understand the above Clinic Etiquette and agree to abide by it.

_____ _____

Parent or Guardian Signature **Date**

6927 Old Seward Hwy. STE. 100
Anchorage, AK 99518
907-345-0050 Phone 907-344-5103 Fax

Child's Name: _____

Date of Birth: _____

ALL FOR KIDS PEDIATRIC THERAPY
SCOPE OF PRACTICE

Characteristics of Persons Served:
Children ages birth to adolescence (less than 14 years of age for new clients and up to 18 years of age for continuing clients) may be served.

Medical Acuity & Medical Stability:
Children must be healthy and cleared for treatment by their physician. Children may not receive services if they have illnesses such as: fever of 100.5 or greater; pink eye; vomiting and/or diarrhea; or other highly contagious viruses and/or diseases.

Admission Criteria:
Children who experience delays, or are at significant risk for delays, in any area of development which negatively affects his/her functional performance and ability to participate in home, community and school activities.

Children from birth through 14 years of age will be considered for evaluation. Children 14 years and older may be seen on a case by case basis if he/she has lost a skill due to an accident or illness.

- Financial responsibility is established in accordance with the Financial Policy.
- An evaluation is completed which identifies the need for intervention.
- Additional factors considered before admission include areas of expertise of therapy staff and availability of appropriate treatment materials and equipment. If a client would benefit from treatment but is not approved for services at AFKPT due to the factors previously identified, he/she may be referred to other agencies that can provide needed services.
- Reports less than 3 months old for children under 3 years of age and less than 6 months old for children over 3 years of age from other agencies will be reviewed and may be accepted in lieu of performing an evaluation.

Discharge Criteria:
It is the policy of AFKPT to discharge clients who meet any of the following criteria: are 18 years of age; no longer demonstrate need for intervention; do not appear to benefit from continued services; are not meeting financial responsibilities to AFKPT; do not meet the required attendance; are removed at the request of the caregiver; or are removed at the discretion of the agency (including for safety reasons).

- **No Longer Demonstrates Need**:
  If a child has demonstrated sufficient progress in therapy and testing reveals the child's skills are at age-appropriate levels (i.e., no further intervention is indicated), the therapist will review the child's progress with the caregiver and plan a discharge date.

- **Does Not Appear to Benefit**:

Progress in therapy is reviewed on a continuous basis. If a client does not meet therapy goals and/or does not demonstrate progress on re-evaluation after six months in therapy, the treating therapist will discuss the lack of progress and the treatment plan with their clinical supervisor and the child's caregiver. They may revise the treatment plan to better fit the child's needs at any time.

If a client does not meet therapy goals and/or does not demonstrate progress on a re-evaluation during the second six month treatment period, the treating therapist will discuss the treatment plan with their clinical supervisor and the child's caregiver. An interdisciplinary team review shall be initiated. This discussion will include the possibility of revising the treatment plan, increasing or decreasing the frequency of sessions, and discharge if no progress continues to be noted.
At the end of 18 months of treatment, if no progress has been noted and the above steps were taken, the client may be discharged.

6927 Old Seward Hwy. STE. 100
Anchorage, AK 99518
907-345-0050 Phone 907-344-5103 Fax

- **Financial Responsibility:**
  If a family is not meeting financial responsibilities to the agency as outlined in the Financial Policy, the client may be discharged from therapy.
- **Poor Attendance:**
  Poor attendees may be discharged per the Attendance Policy.
- **Caregiver Request:**
  Discharge will be completed upon caregiver request.
- **Agency Discretion:**
  The agency reserves the right to discharge any client at any time for any reason.

Changing Therapists

A child may, at one time or another, experience a change in his or her therapist. This may happen for any one of the following reasons:

- Therapist relocation
- Therapist illness or family emergency
- Scheduling issues in which the family requests a different day of the week or time of day for ongoing therapy sessions. We will accommodate changes as they arise; however, this will occasionally result in the child switching therapists.
- Lack of progress or 'connection' with the child's assigned therapist. Our number one goal is for the child to receive a maximum benefit from therapy. Occasionally, a child has a personality conflict with the assigned therapist or just doesn't develop a good working relationship with the assigned therapist. In cases like this, it is in the best interest of the child to re-assign them to a different therapist. Additionally, the child or therapist may reach a point where the child still needs therapy but is failing to make acceptable progress. The change to a new therapist may assist the child to begin making progress once again.
- Change in the specific therapist's schedule.

We make every effort to maintain continuity of care with as few changes as possible. When changes do arise, we will assist families in making the transition as smooth as possible.

Evaluation and Intervention:

Therapeutic evaluation and intervention is provided by state licensed and appropriately credentialed occupational therapists, physical therapists, and speech-language pathologists. Occupational therapy assistants, speech-language pathology assistants, and physical therapy assistants provide services under the supervision of an occupational therapist or speech-language pathologist or physical therapist. In a collaborative process with the child and his/her caregiver, outcomes for therapeutic intervention are created and reassessed every 6-12 months to determine frequency and duration of service.

Occupational therapy evaluation and intervention focuses on factors affecting the child's independence in their occupations in the home, school, and play environments. A child's occupation includes play, learning, peer interaction, and self-care skill development. Intervention techniques utilized are based on clinical reasoning, theories of occupational therapy practice, and evidence based practice. Intervention techniques include but are not limited to:

- Neurodevelopmental treatment approach
- Sensory Integration and modulation techniques
- Aquatic therapy
- Normal development of fine motor and visual motor skill activities
- Adaptive equipment
- Positioning equipment
- Oral motor intervention
- Cranio-sacral therapy
- Education of caregivers, child and family members
- Therapeutic Listening and Integrated Listening Systems (iLs)
- DIR Floortime

6927 Old Seward Hwy. STE. 100
Anchorage, AK 99518
907-345-0050 Phone 907-344-5103 Fax

Child's Name: _____

Date of Birth: _____

Physical therapy evaluation and intervention focuses on factors affecting mobility in the home, school, and play environments. Intervention techniques utilized are based on clinical reasoning, theories of physical therapy practice and evidence based practice. Intervention techniques include but are not limited to:

- Neurodevelopmental treatment approach
- Aquatic therapy
- Normal development of gross motor skill activities
- Adaptive equipment
- Positioning equipment
- Orthotic development
- Myofascial release
- Education of caregivers, clients, and family members

Speech therapy evaluation and intervention focuses on factors affecting the child's speech, language, peer relationships, feeding and swallowing skills, and social skills in the home, school, and community environments. Intervention techniques utilized are based on clinical reasoning, theories of speech therapy practice, and evidence based practice. Intervention techniques include but are not limited to:

- Normal developmental sequences of expressive and receptive communication
- Oral motor intervention for feeding and swallowing safety
- Articulation intervention techniques
- Augmentative device selection, design, and programming
- Education of caregivers, clients, and family members

Settings, Hours, and Days of Service:
Therapy is provided in an outpatient therapy setting at the Dimond Athletic Center for aquatic therapy, and the Chamberlin Equestrian Center (for summer hippotherapy sessions). In general, therapy services are provided between the hours of 7 AM and 6 PM, Monday through Friday.