Dear Parent/Guardian,

Thank you for contacting us regarding therapy services for your child. Due to the demand for Physical, Occupational, and Speech Therapy in our area, we are currently managing a wait list for all three services and are revising our intake process in order to better serve the community. The first step is to completely fill out the attached paperwork to the best of your ability and return to our facility with a prescription for therapy from your physician.

**Prescription Requirement:** I understand that my child cannot receive therapy services unless there is a current written prescription from my child’s primary care physician on file with TC. (The prescription for therapy must be dated within the past 12 months and list the specific therapy service my child is to receive.)

TC will not provide services to children who are currently receiving the same services (PT, OT, or Speech) with any other facility. If your child is receiving services anywhere else, other than at school, please discuss with your therapist.

Once the paperwork is received and determined to be complete, you will be placed on a waiting list for services. As appointments become available, we will call you to schedule an evaluation. Please be sure to contact us if any information has changed. If we are unable to reach you, your child will be removed from the waiting list and will not receive and evaluation from Turn Center. In the event that you are seeking services for multiple disciplines, you will be schedule separate evaluations at different times.

Evaluations typically take one hour and once the evaluation is complete, our therapists will determine if your child needs therapy services. We will contact you as soon as possible following the evaluation to set up your child’s therapy schedule. Our fist appointments are at 8:45 am and the last appointment is scheduled at 5:30pm. There is no guarantee as to availability of any specific appointment time.

The following paperwork must be received before your child can be added to our waiting list:

- Medical History Forms
- Consent Forms
- Speech Intake Forms (if requesting speech therapy)
- Prescription for specific therapy discipline (OT, PT, ST) “evaluation and treatment”

Please feel free to contact us at any time if you have any questions. We look forward to meeting you and your child soon at the time of their evaluation.
CASE HISTORY FORM

Dear Parent/Guardian:

Please complete the following Case History Form and return it to Turn Center prior to your child’s initial PT/OT/ST evaluation. Thank you.

Date: ______________________

Name of person completing Case History Form: _____________________________________________

Relationship to child: _____________________________________________________________________

Language(s) spoken in the home: ____________________________________________________________

Language: ____________________________ Services Requested: _____Occupational Therapy

___English

___Interpreter needed

___Physical Therapy

___Speech Therapy

IDENTIFYING INFORMATION/FAMILY HISTORY:

Child’s Name: Last: _________________________ First: ___________________________ MI: ___________

Date of Birth: ___________________________ Age: ___________ Sex: ____Male ____Female

Street Address: _____________________________________________________________

City: ___________________________________________ State: ____________ Zip: ________________

Primary Diagnosis: _____________________________________________________________________

Other Diagnosis: _______________________________________________________________________

Mother/Guardian’s Name: ___________________________________________ Age: ___________

Address: _____________________________________________________________________________

Education: ___________________________ Occupation: ___________________________ Work Phone #: ________________

Employer: ___________________________ Email: _______________________________________________________________________________

Cell #/Carrier: ___________________________ Home #: _________________________________

Turn Center Patient Intake Packet, Updated May 2020
Father/Guardian’s Name: ___________________________________________ Age: ________

Address: ________________________________________________________________________________

Education: ___________________________ Occupation: ___________________________

Employer: ___________________________ Work Phone #: ___________________________

Email: ________________________________________________________________________________

Cell #/Carrier: ______________________ Home #: ___________________________

Emergency Contact (other than parent or guardian):
Name: ___________________________ Phone #: __________________________ Relationship: ____________

Brothers and sisters: (living at home)

Name: ___________________________ Age: __________________________

Name: ___________________________ Age: __________________________

Name: ___________________________ Age: __________________________

Name: ___________________________ Age: __________________________

Others living in your home:

Name: ___________________________ Relationship: ______________________

Name: ___________________________ Relationship: ______________________

EDUCATIONAL INFORMATION:

Child’s school: ___________________________ Phone #: ___________________________

Grade: _______ Teacher’s Name: ___________________________

Does your child receive special education services, PT/OT/ST? If so, please include length of time per day:

Does your child attend daycare: _____Yes ____No If yes, how many hours in a day? ___________

Any customs, religious beliefs, or wishes that might affect care? _________________________________

Has your child received therapy services in the past?

Type (PT/OT/ST): ___________________________ Where: ___________________________

Is your child currently receiving therapy services at another facility?

Type (PT/OT/ST): ___________________________ Where: ___________________________
MEDICAL/DEVELOPMENTAL INFORMATION:

Child’s Family Physician: _________________________________________________________________

Address: _____________________________________________________________________________

Phone: ___________________________ Date child was last seen by this physician _________________

Is this child seeing a specialist? ___Orthopedist Name: ____________________ City: ______________

___Neurologist Name: ____________________ City: ______________

Other: __________________________ Name: ____________________ City: ______________

Please check if your child is being followed by a doctor(s) at:

_____ Cook Children’s Hospital, Ft. Worth  _____ Shriner’s Hospital, Houston

_____ Scottish Rite Hospital, Dallas  ________________________other

Please describe your child’s birth story. List any complications during pregnancy, birth, or infancy:
_____________________________________________________________________________________
_____________________________________________________________________________________

Birth weight: __________ pounds ___________ounces        APGAR scores:______________

Was your child premature: ____Yes _______No if yes, he/she was born at ________________weeks.

Was your child in NICU: _____Yes _____No if yes, how long? ________________________________

If yes, please list the reason
_____________________________________________________________________________________
_____________________________________________________________________________________

Please list any childhood illnesses and/or medical conditions (past and present):
_____________________________________________________________________________________
_____________________________________________________________________________________

Name of Current Medication  Amount and How Often  Reason
_____________________________________________________________________________________
_____________________________________________________________________________________

Medication Allergies: _____Yes _____No if yes, please list ___________________________________

Food Allergies: ___ Yes ____No if yes, please list _____________________________________________

Medical Safety Precautions that we need to be made aware of while evaluating/treating your child:
_____________________________________________________________________________________
_____________________________________________________________________________________

Turn Center Patient Intake Packet, Updated May 2020
Please rate your child’s general health:

_____ Excellent _____ Good _____ Fair _____ Poor

Has your child had any surgeries or hospitalizations _____ Yes _____ No

<table>
<thead>
<tr>
<th>Type of surgery</th>
<th>Year</th>
<th>Reason</th>
<th>Physician</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does your child suffer from chronic ear infections? Please describe frequency and treatment:

_____________________________________________________________________________________

Has your child had a formal eye examination? Please describe:

_____________________________________________________________________________________  

Has your child had a hearing test? Has your child had tubes in his/her ears, hearing aids, or cochlear implants? Please describe:

_____________________________________________________________________________________

DEVELOPMENTAL MILESTONES:

<table>
<thead>
<tr>
<th>Speech Skills</th>
<th>Age</th>
<th>Motor Skills</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babbling</td>
<td></td>
<td>Rolling</td>
<td></td>
</tr>
<tr>
<td>First Word</td>
<td></td>
<td>Sitting unassisted</td>
<td></td>
</tr>
<tr>
<td>2 Word Utterance</td>
<td></td>
<td>Crawling</td>
<td></td>
</tr>
<tr>
<td>Phrases/Sentences</td>
<td></td>
<td>Walking</td>
<td></td>
</tr>
<tr>
<td>Chewing solid foods</td>
<td></td>
<td>Drinking from a cup</td>
<td></td>
</tr>
<tr>
<td>Reaching</td>
<td></td>
<td>Spoon feeding self</td>
<td></td>
</tr>
</tbody>
</table>

EQUIPMENT:

Does your child currently use any adaptive assistive equipment? ___ Yes ___ No If yes, please check those applicable: ____ Braces _____ Crutches _____ Walker ____ Manual Wheelchair _____ Power Wheelchair ____ Hand Splints ____ Other: (List) ________________________

If your child uses a wheelchair, how old is the equipment? _____ Less than one year _____ 1-3 years _____ 4-5 years _____ More than 5 years

Does your child need equipment that he/she does not presently have or has outgrown? _____ Yes _____ No ____ Braces ____ Walker ____ Crutches ____ Manual Wheelchair ____ Power Wheelchair ____ Hand Splints ____ Bath Chair ________________________________ Other
SENSORY ISSUES:
My child seems overly sensitive to light/sounds _____ Yes _____ No
My child seems overly sensitive to touch/movement ____ Yes ____ No
My child will only eat certain types of food ______ Yes _____ No
If yes, please list the types _______________________________________________________________

UNDERSTANDING LANGUAGE? COMMUNICATING:
Does your child react or respond to sounds? When you talk to your child, how much does he/she understand (a few words, phrases, directions)? ____________________________________________
__________________________________________
__________________________________________
__________________________________________

SOCIAL BEHAVIOR:
Please describe any social concerns (short attention span, interaction with children and adults, overactive, aggressive behaviors): ______________________________________
 __________________________________________

FEEDING/SWALLOWING:
Please describe any feeding and/or swallowing concerns: (difficulty biting/chewing, accepting new foods/textures): ______________________________________
 __________________________________________

CHILD OBSERVATIONS:
Please describe how your child ascends/descends stairs: ________________________________

Has your child established a hand preference? Right ___ Left ___
Please describe how much help, if any, your child requires for self-care skills (dressing, bathing, feeding, etc.) __________________________________________________________________________

Describe your child’s balance skills and motor coordination: ________________________________

Please list any activities that your child particularly enjoys or does well and anything that may be useful as rewards: ________________________________________________________________

____________________________________________________________________________________
ADDITIONAL INFORMATION:

What is it about your child that concerns you? ________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Do you have specific goals for your child in the next 12 months that could be helped with therapy?
(Please be more specific than “to get better”)

PT: ___________________________________________________________________________________

OT ___________________________________________________________________________________

Speech: _______________________________________________________________________________
INSURANCE AND FINANCIAL INFORMATION

Guarantor
Person Responsible for Account (Last, First, MI) ________________________________

Relationship to Patient _____________ Date of Birth _____________ Soc. Sec. # _______________

Address (if different from Patient) _______________________________________________
Address City State Zip

Guarantor Employer ____________________________ Occupation ___________________

Employer Address ____________________________________________________________________
Address City State Zip Phone

Primary Insurance
Subscriber Name __________________________ Relationship to Patient _______ Date of Birth _______

Address (if different from Patient) ________________________________________________
Address City State Zip

Subscriber Employer ____________________________ Insurance Company ______________

Additional Insurance
Subscriber Name __________________________ Relationship to Patient _______ Date of Birth _______

Address (if different from Patient) ________________________________________________
Address City State Zip

Subscriber Employer ____________________________ Insurance Company ______________
PAYMENT POLICIES AND ASSIGNMENTS OF BENEFITS

Please check the appropriate selection below:

○ Patient named below is covered by private insurance or is not insured. I understand that I may apply for financial assistance; otherwise I will be responsible for charges billed by Turn Center after insurance determination.

○ Patient named below is currently enrolled in a federally or state administered program, including Texas Medicaid, DARS, DDS/DRS or Veterans Administration Services, with whom Turn Center is contracted for patient care.

If eligibility ends or is terminated for any reason, I understand that I may apply for financial assistance; otherwise I will be responsible for charges billed by Turn Center after Medicaid or insurance determination.

Although you may be assisted by private insurance, Medicaid, or other source of assistance, payment for services received by you or your family is ultimately your responsibility. Cash, personal checks, MasterCard, Visa, American Express, Discover and debit cards are accepted. Payment is required at the time of service or by monthly statement.

Turn Center offers a sliding fee scale payment arrangement based on household income/expenses for patient families who might otherwise be unable to afford the cost of ongoing occupational, physical or speech therapy services. Please contact the Business Office to apply.

ASSIGNMENT OF BENEFITS

I hereby assign to Turn Center all benefits provided under any healthcare plan, medical policy, motor vehicle insurance and/or any other entities paying on my behalf, otherwise due or payable to me provided the amount of such benefits shall not exceed the amount of said professional service charges. I understand that I am personally responsible to Turn Center for all charges not covered by this assignment and that a photocopy of this Assignment shall be considered as effective and valid as the original.

___________________________________  ____________________
Parent/Guardian’s Printed Name       Date
___________________________________
Parent/Guardian’s Signature
INSURANCE AUTHORIZATION POLICY

Dear Parent:

As of April 1st, 2017, Turn Center will schedule therapy when physician’s approval of evaluation has been received and authorization is in place.

- If Turn Center is unable to obtain authorization, you may:
  - Self-pay;
  - Complete and return the application for financial assistance prior to start of therapy services.

Please note, if therapy services are denied authorization, the case will be reviewed by an internal team to best determine a plan of care for your child.

If you have any questions, please do not hesitate to contact Regan Hall, Director of Therapy Services, or Whitney Mueller, Director of Business Services.

Sincerely,

Regan Hall
Director, Therapy Services

Whitney Mueller
Director, Business Services
DEMOGRAPHICS

This information is confidential and will not be shared with anyone else. Please complete all questions. Thank you!

Child’s Name: __________________________ DOB: __________ Gender: ___Male ___Female

Name: __________________________________________________________
Relationship: __Mother__Father__Other____
Address: _______________________________________________________
City/State/Zip: _________________________________________________
Home #: ________________________________
Cell #/Carrier: ________________________________ Email: ________________
Employer: ____________________________________________________________________
Occupation: ___________________________________________________________
Address: ___________________________________________________________
City/State/Zip: _________________________________________________
Work #: ___________________________________________________________

1. What type of insurance do you currently have?
   ___No Insurance
   ___Medicaid
   ___Private Insurance
   ___SSI/Disability

2. What is your ethnicity?
   ___Asian
   ___Black or African American
   ___Caucasian (Non-Hispanic)
   ___Hispanic/Latino
   ___Pacific Islander
   ___Others
   ___Decline to Answer

3. What is your annual income?
   ___Less than $10,000  ___$60,001-$70,000
   ___$10,000-$20,000  ___$70,001-$80,000
   ___$20,001-$30,000  ___$80,001-$90,000
   ___$30,001-$40,000  ___$90,001-$100,000
   ___$40,001-$50,000  ___$100,000 & over
   ___$50,001-$60,000

4. How many people are in your household?

5. Referral Source (if referred by physician)

Turn Center Patient Intake Packet, Updated May 2020
6. What is the reason you are seeking services at Turn Center? Check all that apply.

__Insurance ran out
__No longer qualify for Medicaid
__Do not have private insurance
__Medicaid is primary insurance
__Have other insurance, prefer to come to Turn Center
__It is the only facility that has the program

7. How did you hear about Turn Center?

__Physician    __Employer
__Hospital     __Facebook
__TV           __Self
__Internet     __Friend ____________
__Newspaper    __Other ____________

8. What is your child’s diagnosis?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

CONSENT TO TREAT

The State of Texas
County of Potter

WHEREAS, the undersigned are the parent/guardian of:

(Child’s Name)

______________________________DOB________________________and,

WHEREAS, WE desire that said child shall receive treatment without charge to us or the child at the Turn Center in Amarillo, Texas; and, we wish to waive and release any and all claims arising in our favor or in favor of said child in connection with said matter.

NOW, THEREFORE KNOW ALL MEN BY THESE PRESENTS: That we hereby request said Turn Center to furnish treatment for our child. In case of any character of injury or damage to said child growing out of in said Center, whether the same should occur at the Center or en route to or from the same, we the undersigned, hereby waive and release any and all claim or claims which we or said child may now or hereafter have against any person in anywise connected with said Center or in any way acting for it as a part of its treatment program or in consideration of the treatment therefore given, or to be hereafter given, to said child.

I hereby authorize the above named individual for participation in the following activities if their evaluation indicated the need for this service; medical clinics, wheelchair clinics, orthotic clinics, splinting and casting applications, occupational, speech and/or physical therapy intervention, dyslexia, counseling, aquatic therapy, and Turn Center sponsored activities.

Parent/Guardian: ___________________________________________ Date: ______________

Witness: _________________________________________________ Date: ______________

____(Initial) Although general referrals to physicians and/or vendors are provided as a courtesy to our clients, TC does not endorse any physician or vendor over another. TC does not make any representations and cannot be held responsible for any interactions or treatments mutually agreed upon between you and the physician or vendor you choose.
AUTHORIZATION TO DISCLOSE THERAPY RECORDS

As a parent and/or legal guardian of _____________________________ DOB: _____________________

I specifically authorize the release of information specified below only to the individual(s) listed on this form.

___ Complete Copy of All Records
___ Telephone/Verbal Communication
___ Counseling & Consultation Visits
___ Condition and Dates of Visits
___ Other, please specify: ________________________________________________________________

Please list names and information of individuals, including yourself and your spouse, who have your permission to your child’s medical records and information.

1. Name: ___________________________________ Relationship to Child: ____________________
   Address: ___________________________________ Phone Number: ____________________

2. Name: ___________________________________ Relationship to Child: ____________________
   Address: ___________________________________ Phone Number: ____________________

3. Name: ___________________________________ Relationship to Child: ____________________
   Address: ___________________________________ Phone Number: ____________________

4. Name: ___________________________________ Relationship to Child: ____________________
   Address: ___________________________________ Phone Number: ____________________

___ I understand that I have the right to revoke this authorization, but I must do so in writing and it will not apply to information previously released by the authority of this document.

___ I also understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may be protected by federal privacy laws.

___ I understand authorizing the disclosure of the information identified above is voluntary.

____________________________________ Date: __________________
Signature of Parent/Legal Guardian

____________________________________ Date:  __________________
Signature of Witness
CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Client Name: ___________________________________ DOB: ____________________________________________
Address: ______________________________________ City: __________________ State: __________ Zip: ___________

We are requesting that you authorize the agencies or persons named below to disclose to each other confidential information regarding the above named client.

____________________________________ AND ______________________________________
Name and Position of TC Staff Person/Agency

Turn Center

Address: 1250 Wallace Blvd
Amarillo, Texas 79109
Phone: (806)-353-3596
Fax: (806)-353-4927

Records to be released/disclosed: ___ Evaluation Report ___Treatment Records ___Medical Record

Purpose of release/disclosure:
___To provide information to client’s therapy and/or medical treatment
__Other: __________________________________________________________________________________________

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specific information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). 45 CFR §164.508(c)(1)(iii). I understand that treatment or payment cannot be conditioned on my signing this Authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this Authorization in writing at any time except to the extent that action has been taken in reliance upon the Authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law. 45 CFR §164.508(c)(2)(i); 45 CFR §164.508(c)(2)(ii): This Authorization will expire One Hundred and Eighty (180) days from the date of my signature below, unless I revoke the Authorization prior to that time or unless specified by date, event, or condition as follows:

___________________________. 45 CFR § 164.508 (c)(1)(v)

Date of Signature: __________________ Signature: ____________________________________________

Patient or legal authorized representative 45 CFR § 164.508(c)(1)(vi)

Printed Name: ____________________________________________________________

Relationship to Patient 45 CFR (c)(1)(iv):

Address: __________________________________________________________________________
Telephone: _________________________________________________________________________

Turn Center Patient Intake Packet, Updated May 2020
Welcome to Turn Center. We are pleased that your child will be receiving services here at the center.

Turn Center is a 501(c)(3) non-profit organization supported by the generosity of the citizens of Amarillo, Texas. The vision of the board of directors is that children with disabilities should receive basic therapy services at no charge to the children or their families. For this reason we have an extensive waiting list of children requiring our services. Therefore, please review the following adopted policy:

1. If your child has two (No Call – No Show) appointments in a month, they will be discharged from therapy and their slot will be given to the next child on the waiting list. We know that some children have health and medical issues that may interfere with a regular therapy schedule. A non-traditional therapy schedule may be considered for those with severe health and medical issues which may consist of home exercise programs, less frequent therapy sessions (i.e. once a month), etc. Visit with your therapist about your child’s particular scheduling needs and how you will deal with them, together. Please communicate with your therapist about a best plan for your child.

2. Each child is required to have an overall attendance rate of 50% for all treatment sessions, per discipline, per month. If a child has two NCNS’s or does not meet the 50% attendance rate each month, the therapy slot will be given to the next child on the waiting list and they will be discharged from therapy services. ***If your child is sick, please bring a doctor’s note and this will be considered an excused absence.***

3. Cancellations: If cancelling a child’s appointment please do so at your earliest convenience. Cancellations 45 minutes or closer to appointment will be marked as a No call-No show.

_____________________________________________ Date: _____________________________
Parent/Guardian Signature
INFORMATION RELEASE FOR PUBLIC USE

Child’s Name_________________________________ Date______________________________

_____ I DO NOT want my child’s photograph to be used in any publicity by Turn Center.

_____ I give my permission for my child to be photographed/videoed by the staff of Turn Center, newspaper photographers, and TV reporters to be used for the purpose of:

___ Staff training, fundraising events, video presentations in the community, and/or public relations campaigns and publicity materials but not limited to brochures, slideshows, newsletters, Turn Center website, newspaper ads, and Turn Center’s FaceBook page.

___ I give permission for my child’s therapist to use their personal device to create a video and/or photograph for the purpose of a therapeutic strategy. This video and or photograph may be edited and the final product will only be distributed to parent/guardian then permanently deleted from the therapist’s device.

___ I DO NOT give my permission for the therapist to use their personal device.

___ I give Turn Center my permission to share my child’s diagnosis and general information about therapy sessions, goals, and progress in staff training, fundraising events, video presentations in the community, and/or public relations campaigns and publicity materials, but not limited to brochures, slideshows, newsletters, Turn Center website, newspaper ads and Turn Center’s FaceBook page.

___ I give Turn Center permission to conduct a tour during my child’s session.

Please list any exceptions to the above items where you do not want your child’s picture or diagnosis and general information to be included.

_________________________________________________________________________________

This publicity release is granted from the above date and may be revoked or changed by the parent/guardian at any time by submitting a written request to Turn Center.

I have read and do understand this document.

_________________________________________  _______________________________________
Parent/Guardian Name  Parent/Guardian Signature

(Please Print)

Turn Center Patient Intake Packet, Updated May 2020
Team Responsibility Agreement

Patient Name: _______________________________ Date of Birth: _______________________________

**Therapist Responsibilities:**
1. Our goal is to provide each patient with the skills to function at their very best at home, in school, and out in the community.
2. We will create a treatment plan specific to your child and his/her needs based on test results, identified strengths, identified weaknesses, clinical judgement, and goals set by the child’s family.
3. We will provide open communication with the family regarding home program recommendations, suggested community services and other professionals that your child might need to see.

**Family Responsibilities:**
1. The primary caregiver must be present for all OT, PT, and ST evaluation(s)/re-evaluations and quarterly progress reviews.
2. Bring your child to all scheduled sessions on time. If your child is sick, please obtain a doctor's note at visit and bring to the next session.
3. For the best outcome, parents are asked to follow through with home recommendations made by the therapist. Lack of participation in HEP and follow through at home could result in dismissal from therapy services.
4. We encourage constant and open communication for your child to have the best outcomes. Please email your therapist or call them at Turn Center with any questions or concerns.

**Possible Reasons for Discharge:**
1. All goals set by the therapist at the initial evaluation are met and therapy is no longer recommended.
2. A plateau has been made regarding progress toward therapy goals. At this time, episodic care will be discussed.
3. Your child misses 2 or more therapy sessions in a row without calling to cancel.
4. Your child does not maintain an attendance rate of 50% (with exceptions of missed appointments due to illness and obtaining a doctor’s note), each month, for all treatment sessions.
5. The child’s behavior prevents their ability to participate in sessions and make progress towards set goals.

I have read this agreement and understand my responsibilities and why they are important.

_________________________________________________________  ____________  ____________
Parent/Legal Guardian’s Signature  Date

_________________________________________________________  ____________  ____________
Therapist’s Signature  Date
PARENT INFORMED CONSENT FOR STUDENT THERAPISTS

Turn Center provides learning experiences for many students who are studying to become future physical, occupational, and speech therapists. We are proud to be considered a teaching facility and frequently have students who have come to TC for their pediatric rotation. While here at TC, each student therapist may have the opportunity to follow your child’s therapist to observe various treatment sessions, to plan their own treatments for your child and eventually to lead the therapy session on their own with the supervising therapist nearby for assistance if needed.

Each child’s care is our top priority. Your child will receive the same quality therapy and care with a student therapist as they would with their regular therapist. Therapists spend plenty of time supervising, training, and discussing your child’s diagnosis and plan of care thoroughly. Your child’s therapist will evaluate any possible safety concerns before the student therapist is allowed to work with your child by themselves.

It is of great benefit for your child to be seen by a student therapist. The student will come with the latest research and will have fresh set of eyes to try new therapy activities with your child. It will also benefit the patient to listen to and adjust to another adult.

I understand that my child will at some point receive therapy services which will be provided by a student therapist at Turn Center. I understand that my child’s therapist will be closely supervising the students; however, may not always be in the room during therapy sessions.

___________________________________  ____________________
Parent/Guardian’s Printed Name           Date

____________________________________
Parent/Guardian’s Signature
TURN CENTER POLICIES TO REMEMBER:

In case of **FOUL WEATHER**:
- Turn Center will follow the guidelines recommended by AISD for center closure or delayed opening.
- A message will be place on the Center answering machine explaining alternate hours of operation for the day based on the recommendation per AISD.

In case of **CHILD ILLNESS**:
- Your child must be free of vomiting and diarrhea 24 hours **prior to their appointment**.
- Your child must be fever free for 24 hours **prior to their appointment** without the assistance of fever reducing medication.
- Parent should make their best judgement regarding their child’s ability to tolerate treatment sessions and the safety/well-being of other clients.
- Parent is responsible for calling and notifying TC of cancellation prior to your appointment time.

Regarding **PRIVACY**:
- No personal photography or videos are permitted during your visit to TC.
- If you wish to capture your child through video or pictures, please speak with your therapist.
- Parent must be invited to attend a therapy session. To protect the privacy of other clients, roaming the facility without authorization is not allowed

Regarding **ATTENDANCE**:
- Consistent attendance is crucial for therapeutic benefit.
- The client must meet overall attendance of 50% each month.
- If a client has missed 2 consecutive sessions without calling the Center for notification it is an automatic discharge from therapy services.
- 4 consecutive weeks are permitted for client vacation. Time period’s longer than 4 consecutive weeks are subject to risk treatment spot.

Regarding **PRESCRIPTION REQUIREMENT**:
- Therapy services cannot be received unless a current written prescription from the primary physician is on file with Turn Center.
- The prescription must be dated within the past 12 months and list the specific therapy disciplines (OT, PT, ST) to be received.
- A client is given up to 3 weeks to obtain needed prescription for services following an evaluation.