



## **Tots To Teens Therapy Services, Inc.**

Welcome to Tots To Teens Therapy Services, Inc.

We are so pleased you have chosen our company for your Speech Therapy needs. Please take a moment to complete the attached forms. All applicable forms must be completed prior to all services. **Completed forms may be given to clinicians, faxed to (703) 594-2640**

**Attn: Halle Raisigel, or mailed to:**

**Tots To Teens Therapy Services, Inc.  
12263 Charles Lacey Drive  
Manassas, VA 20112**

Forms:

Client Questionnaire - Personal Information/History - 2-5 pages (Required)  
Consent for Release of Information - Page 6 – (Recommended)  
Service Agreement Individual - Page 7 – (Required for Individual Services)  
Billing Contract Individual - Page 8 – (Required for Individual Services)  
Tricare Prime Billing Authorization – Page 9 – (Required for Tricare Prime clients)  
Credit Card Charge Authorization Form – Page 10 (Required for all Services)  
Email Authorization - Page 11 – (Recommended)  
Notice of Privacy Practices - Pages 12 - 13 - Please read  
Acknowledgement of Privacy Practices - Page 14 (Required for all Services)  
Important Information Page – Page 15 Please keep for your reference



**Tots To Teens Therapy Services, Inc.**  
**Client Questionnaire**

Patient's Full Name \_\_\_\_\_  
  First  Middle  Last

Birthdate \_\_\_\_\_ Male \_\_\_\_\_ / Female \_\_\_\_\_  
                        Month                        Day                        Year

Address \_\_\_\_\_  
                        Street  City/State                                Zip Code

Telephone \_\_\_\_\_  
                        Home  Cell  Work

E-mail Address \_\_\_\_\_

Referral Source \_\_\_\_\_

Reason for Referral \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

**PARENT INFORMATION**

Father's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_  
                        Street  City/State                                Zip Code

Father's Employer and Address \_\_\_\_\_  
  \_\_\_\_\_

Telephone \_\_\_\_\_  
                        Home  Cell  Work

Mother's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_  
                        Street  City/State                                Zip Code

Mother's Employer and Address \_\_\_\_\_



# Tots To Teens Therapy Services, Inc.

Mother's Telephone \_\_\_\_\_  
Home Cell Work

Parent's Marital Status \_\_\_\_\_

Siblings and Birthdates \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other persons living in the home \_\_\_\_\_

Second language spoken in home \_\_\_\_\_

Nature of problem \_\_\_\_\_

Date of Onset \_\_\_\_\_

Has your child previously been evaluated for this problem? \_\_\_\_\_

If yes, where? \_\_\_\_\_ Date of evaluation \_\_\_\_\_

## FAMILY HISTORY

Have any of the following conditions affected members of your immediate family?

Cleft Lip/Palate \_\_\_\_\_ Neurologic Disease \_\_\_\_\_  
Deafness \_\_\_\_\_ Stuttering \_\_\_\_\_  
Delayed Speech \_\_\_\_\_ Other \_\_\_\_\_

Is your child adopted? \_\_\_\_\_ If so, at what age? \_\_\_\_\_

Is he/she aware of the adoption? \_\_\_\_\_

## PREGNANCY AND BIRTH HISTORY

Did you have major health problems, injuries, or surgeries during your pregnancy? \_\_\_\_\_

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## Tots To Teens Therapy Services, Inc.

Check any of the following that were applicable to you during your pregnancy:

German Measles \_\_\_\_\_ High Blood Pressure \_\_\_\_\_

RH/Blood Incompatibility \_\_\_\_\_ Virus Infections \_\_\_\_\_

Other \_\_\_\_\_

How long was your labor? \_\_\_\_\_

Describe any labor complications \_\_\_\_\_

How long was your pregnancy? \_\_\_\_\_

What was your baby's birth weight? \_\_\_\_\_

Were there any complications at the time of delivery? \_\_\_\_\_

If so, explain \_\_\_\_\_

### **EARLY DEVELOPMENTAL HISTORY**

After birth, did the baby have any of the following conditions?

Convulsions \_\_\_\_\_ Feeding Problems \_\_\_\_\_

Heart Monitoring \_\_\_\_\_ Serious Infections \_\_\_\_\_

Severe Jaundice \_\_\_\_\_

At what age did your child sit alone? \_\_\_\_\_

At what age did your child walk alone? \_\_\_\_\_

At what age did your child feed self? \_\_\_\_\_

At what age did your child say his/her first word? \_\_\_\_\_

At what age did your child talk in sentences? \_\_\_\_\_

Does your child play with other children? \_\_\_\_\_

Does your child have severe or prolonged temper tantrums? \_\_\_\_\_

Does your child appear to have poor coordination? \_\_\_\_\_



## Tots To Teens Therapy Services, Inc.

Has your child suffered from chronic ear infections? \_\_\_\_\_

Has your child ever had a psychological or neurological exam? \_\_\_\_\_

If so, where? \_\_\_\_\_ When? \_\_\_\_\_

Has your child ever been hospitalized? \_\_\_\_\_

If so, what was the reason? \_\_\_\_\_

Length of stay \_\_\_\_\_ Date \_\_\_\_\_

Is your child currently receiving any other forms of therapy (i.e. occupational or physical therapy) or has he/she received other forms of therapy in the past? \_\_\_\_\_

If so, what type of therapy? \_\_\_\_\_

Dates \_\_\_\_\_

Is your child currently taking medications? \_\_\_\_\_

If so, name of medication \_\_\_\_\_

Reason for medication \_\_\_\_\_

### **EDUCATIONAL INFORMATION**

Name of school child is presently attending \_\_\_\_\_

Describe general progress and behavior in school \_\_\_\_\_

Is your child receiving any special services at school (i.e. speech therapy, occupational therapy, tutoring, etc.?) \_\_\_\_\_

Does your child appear to exhibit learning problems? \_\_\_\_\_

### **PARENT COMMENTS**

Please describe any additional concerns/information you may have about your child's speech and language at this time.

\_\_\_\_\_  
\_\_\_\_\_



Tots To Teens Therapy Services, Inc.

CONSENT FOR RELEASE OF INFORMATION

Patient \_\_\_\_\_

Address \_\_\_\_\_
Street City/State Zip Code

Telephone \_\_\_\_\_

Date of Birth \_\_\_\_\_

I hereby give my consent for release of information concerning the evaluation and treatment of the above patient to the following people:

1. Name \_\_\_\_\_

Address \_\_\_\_\_
Street City/State Zip Code

Telephone \_\_\_\_\_

2. Name \_\_\_\_\_

Address \_\_\_\_\_
Street City/State Zip Code

Telephone \_\_\_\_\_

3. Name \_\_\_\_\_

Address \_\_\_\_\_
Street City/State Zip Code

Telephone \_\_\_\_\_

I understand that Tots To Teens Therapy Services, LLC preserves the confidentiality of client information. I further understand this release is valid for the period of time in which the patient is in active treatment with Tots To Teens Therapy Services, LLC or until revoked by the responsible party. A photocopy of this consent may be used as the original.

Signature of Responsible Party \_\_\_\_\_

Date \_\_\_\_\_



## Tots To Teens Therapy Services, Inc.

### SERVICE AGREEMENT FOR INDIVIDUAL SESSIONS

Speech-Language Pathology and Occupational Therapy Services are provided for the patient with the understanding that payment for such services is the responsibility of the patient, parent, or guardian.

**Payment is required at the time of service unless a Billing Contract has been completed. For all monthly invoicing, payment is due upon receipt of monthly invoice.** A late charge of \$25.00 per month will be assessed on accounts not paid within the two week grace period. Accounts more than 45 days in arrears may result in suspension of service. Accounts more than sixty days in arrears may be sent for collections and all applicable collection fees may be applied to the outstanding balance.

A 24-hour cancellation is required; otherwise, ALL failed appointments will be billed to the responsible party at our regular rate. Two failed appointments may result in cancellation of speech therapy services.

It is the responsibility of the patient, parent, or guardian to file for insurance reimbursement if applicable. Tots To Teen Therapy Services, Inc. is an in-network provider for Tricare Prime. We are a private pay company for all other insurance purposes and do not accept or file insurance claims. We are considered an out-of-network provider for all other insurance companies. A detailed invoice with diagnosis codes will be provided.

All Tricare Prime clients are responsible for obtaining a referral from their Primary Care Manager and a speech therapy authorization from Tricare prior to receiving services. A copy of this authorization may be required.

\*I have read the above policy and agree to comply with said policy. I understand that payment is due at the end of each session unless a Billing Contract has been completed. I agree to pay all monthly invoices upon receipt. I understand that it is my responsibility to file for insurance reimbursement, if applicable.\*

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Signature of Responsible Party

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Date



**Tots To Teens Therapy Services, Inc.**  
**BILLING CONTRACT FOR INDIVIDUAL SESSIONS**

To be completed for all monthly billing arrangements:

Client Name: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
Street City/State Zip Code

E-mail Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_  
Home Cell Work

My preferred form of communication is:

\_\_\_\_\_ Phone – Best time to call is \_\_\_\_\_

\_\_\_\_\_ E-mail

Please send my monthly invoice by:

\_\_\_\_\_ U.S. Mail

\_\_\_\_\_ E-mail (The invoice will be sent as a PDF attachment. Please complete an Email Authorization)

Fees for services rendered are the responsibility of the Client’s Parent/Guardian. **All monthly invoices are due upon receipt and should be paid promptly. A late charge of \$25.00 per month will be assessed on accounts not paid within the two week grace period. Accounts more than sixty days in arrears may be sent for collections and all applicable collection fees may be applied to the outstanding balance.**

\*I have read and understand that payment is due upon receipt of the monthly invoice. I understand that I will be assessed a late charge if payment is not made within two weeks of the monthly invoice date. I understand that if I neglect payment for more than sixty days, my account may be sent for collections and all applicable fees may be added to the outstanding balance.\*

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date





**Tots To Teens Therapy Services, Inc.**

**TRICARE PRIME BILLING AUTHORIZATION**

Client Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_

\_\_\_\_\_  
City, State, Zip Code

Home Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Other Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Client's Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month/Day/ Year

**INSURANCE INFORMATION:**

Sponsor's Name: \_\_\_\_\_

Sponsor's Social Security #: \_\_\_\_\_

Client's Relationship to Sponsor: \_\_\_\_\_

**REFERRAL INFORMATION:**

Referring Physician: \_\_\_\_\_

Do you have an insurance authorization for Speech Therapy: Yes No

**AUTHORIZATION TO BILL INSURANCE:**

**Patient or Authorized person's signature:** I understand that I am responsible for all services provided by Tots To Teens Therapy Services, Inc. I authorize Tots To Teens Therapy Services, Inc. to submit claims to Tricare Prime on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Printed Name of Person Responsible for Account:

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



## Tots To Teens Therapy Services, Inc.

### Credit/Debit Card Charge Authorization Form

I authorize Tots To Teens Therapy Services, Inc. to charge the credit/debit card listed below, for services rendered and any related expenses. I further understand that it is my responsibility to notify Tots To Teens Therapy Services, Inc. of any changes to my credit/debit card information including address, zip code, updated expiration date, account number, and security (CVC) code. I understand I will be responsible for any bank chargeback fees in the event this information is not kept up to date.

### Credit/Debit Card Information



Credit Card # \_\_\_\_\_

Name as it appears on Credit Card: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Security (CVC) Code \_\_\_\_\_

Billing Address: \_\_\_\_\_

Zip Code: \_\_\_\_\_

### **Please Choose One of the Following Options:**

\_\_\_\_\_ I hereby give consent for my credit card listed above to be charged the full amount due to Tots To Teens Therapy Services, Inc. on the first of the month following services. I will be provided with an electronic invoice receipt after payment is charged.

\_\_\_\_\_ I prefer to pay my monthly invoice by check/ACH Intuit Payment Network/Cash. My credit card listed above will only be charged if payment is not received by the last day of the month following services. A \$25.00 late fee will be added to the total amount due.

Authorized Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Printed Name: \_\_\_\_\_



## Tots To Teens Therapy Services, Inc.

### Email Authorization

If you wish to communicate through the use of internet email, please complete the authorization below. In doing so, you authorize Tots To Teens Therapy Services, Inc. to send evaluations, therapy notes, general client correspondence, billing invoices and statements via the internet.

\*I, \_\_\_\_\_, authorize Tots To Teens Therapy Services, Inc to communicate with me through the use of internet email.

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Print Name

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Signature

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Date

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Email Address



## Tots To Teens Therapy Services, Inc.

### NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

### OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your health information. We must provide you with this Notice about our privacy practices, our legal responsibilities, and your rights concerning your health information. We will abide by the terms of this notice effective 1/1/2012, remaining in effect until replaced. We will accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling (703) 963-9066 and requesting a copy of our "Notice".

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services for you. This includes health insurance companies as well as any business associate helping us obtain payment.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations to include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of health information for treatment, payment, or healthcare operations, you may give us written authorization to use or disclose your health information to anyone for any purpose. Unless you give written permission, we cannot use or disclose your health information for any reason except those described in this Notice. Authorization may be revoked at anytime with written notification.

To Your Family and Friends: Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care only if you agree that we may do so or in an emergency.



## **Tots To Teens Therapy Services, Inc.**

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to any correctional institution or law enforcement official having lawful custody of protected health information to the extent necessary to avert serious threat to your health or safety or the safety of others.

Correspondence: We may use or disclose your health information to provide you with company correspondence, courtesy calls, and reminder calls through voicemail messages, emails, postcards, or letters.

### **PATIENT RIGHTS**

Access: You have the right to look at or get copies of your health information. You must make a request in writing to obtain access to your health information. Please send written requests to  
Tots To Teens Therapy Services, Inc.  
12263 Charles Lacey Dr., Manassas, VA 20112.

Disclosure: You have the right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations, or correspondence. If you request this disclosure more than once in a 12-month period, we reserve the right to charge you a reasonable fee to offset the costs of additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use and disclosure of your health information. Although we are not required to agree to such requests, we will make every effort to acknowledge reasonable requests.

### **TO REQUEST INFORMATION OR FILE A COMPLAINT**

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact:

Tots To Teens Therapy Services, Inc.  
Halle Raisigel  
Office Manager  
(571) 228-1708



**Tots To Teens Therapy Services, Inc.**

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_, have received or reviewed a copy of Tots To Teens Therapy Services Notice of Privacy Practices.

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement was unattainable because:

Individual refused to sign \_\_\_\_\_

Communication barriers prohibited obtaining acknowledgement \_\_\_\_\_

An emergency situation prevented us from obtaining acknowledgement \_\_\_\_\_



## Tots To Teens Therapy Services, Inc.

### Please Keep This Page for your Reference

#### IMPORTANT INFORMATION

Mailing/Billing Address:

Tots To Teens Therapy Services, Inc  
12263 Charles Lacey Drive  
Manassas, VA 20112

Direct billing questions to:

Halle Raisigel  
Office Manager  
(571) 228-1708 or fax (703)594-2640  
TotsToTeens.Halle@gmail.com

Tots To Teens NPI # 1609049477  
Tots To Teens Tax ID #262257874

Clinicians:

**Jennifer Ruckner**, M.S., CCC-SLP  
(703) 507-1533  
TotsToTeensTherapy@gmail.com

**Patti Minicucci**, M.S., CCC-SLP  
(540) 850-9901  
TotsToTeens.Patti@gmail.com

**Sarah Yerxa**, M.S., CCC-SLP  
(207) 240-8311  
sarah.yerxa@gmail.com

**Laura Barrett**, M.S., CCC-SLP  
(703) 864-6652  
laura.b.barrett@gmail.com

**Renee' Bender**, M.S., CCC-SLP  
(540) 273-2900  
TotsToTeens.Renee@gmail.com

**Kristin Molloy**, M.S., CCC-SLP  
(845) 551-7278  
kmolloyslpl@gmail.com

**Sharibeth Cooper**, M.S., OT R/L  
(630) 728-2224  
[TotsToTeens.Beth@gmail.com](mailto:TotsToTeens.Beth@gmail.com)

**Jennifer Edmunds**, OT R/L  
(540) 623-5119  
edmundsjened@aol.com

**Traci Berry Owens**, M.S., CCC-SLP  
(571) 236-2667  
Tdbowens1@gmail.com

Visit us at our website: [www.TotsToTeensTherapy.com](http://www.TotsToTeensTherapy.com)