Education Play Station, Inc. Therapeutic Services
Billing Policies and Procedures

Welcome! Thank you for selecting Education Play Station, Inc. for your therapy needs. Please take a few moments to familiarize yourself with our office and billing policies and procedures.

We received a referral from your doctor to have your child _____evaluated for therapy services.

☐ Your child's Evaluation is scheduled on _____at _____a.m./p.m. for Speech/Language, Feeding, Occupational or Physical Therapy.

☐ We have tried to contact you to set up the evaluation and have not heard back from you. Please contact us within 7 days at #770-877-9105. If we do not hear from you will close out your referral and inform your doctor.

Evaluations
We schedule all sessions every 30 minutes and make it our goal to be timely so there is minimal wait time. Therefore, we require the following for our evaluations:
1. *Arrive 15 minutes prior to evaluation time*
2. *Have all paperwork **filled out prior** to arrival*
3. *Bring patient's insurance card and parent license.*

On occasion, additional testing is necessary to complete an evaluation, which will be done at subsequent visits. Additional hours are billed at the same rate. The evaluation is followed by an analysis of test results and a written report. We require parents to attend a consultation with the therapist to review the results and discuss the plan of therapy.

Evaluation Rates: Private Pay -$175.00 up to 1 hr. Insurance Submission - $250.00
Rates do not pertain to AAC and feeding evaluations.

Therapy Rates
Private Pay - $60**/**30 min. or $120**/**hr
Insurance Submission - $100**/**30 min. session

Additional Services - $100**/**up to hr
Parent or Family Consultation, School Conferences, and IEP Meetings.

Telephone Consultations
We are happy to answer **short** questions by phone or email without a charge. If the call is more than 5 minutes, parents will be billed $15/15 minutes. We can't bill to insurance, so the parent is responsible for payment.

Insurance Billing
Insurance information will be obtained and verified by the EPS office in advance of your appointment. We will gladly file your insurance for you. Any co-payment, co-insurance or deductible is due at the time of service. Although your insurance company provides benefit information, they ultimately make no guarantee of payment. If any insurance issues occur, we will provide all requested information to the insurance company and will re-file claims if necessary. If for **any** reason your insurance company declines payment, **you** will be responsible for payment of **all outstanding services that have been rendered**. _____ *(Please initial)*

Private Pay Billing
Payment is required at the time of service. We accept cash, credit cards & personal checks. _____ *(Pls. initial)*

Consistent attendance is important to ensure your child's optimal progress towards their therapeutic goals

Cancellation Policy
Although we recognize that unanticipated conflicts sometimes arise in families' schedules, we must maintain a policy of discharging clients following excessive cancellations or no-shows without prior notice.

• Appointments cancelled without at least **24 hours notice or a no show will be subject to a $25 cancellation fee.** This is billed directly to the family as we do not bill cancellations to insurance. Cancellation fees must be paid at next scheduled appt. to continue services.

• If frequent cancellations occur, regardless of the reason, you will be put on notice that your time slot may be given to another client. If cancellations continue after the notice, your appointments will be moved to an "If Time Permits" status, meaning we will only schedule you one day at a time if the therapist has an opening.

• After two no shows, (except in cases of emergency, sudden illness/scheduled surgeries, the client will be removed from the schedule.

• Consecutive treatment sessions for more than one family member are scheduled as a convenience to the parent. When a therapist/Instructor cancels an appointment the parent is still responsible for attendance in the other therapies.

• Please contact Education Play Station at #770-877-9105 with any cancellations as far in advance as possible. Our voice mail is available 24 hours/day and therapist/Instructors can be reached individually through email or telephone.

• We encourage families to re-schedule cancelled sessions whenever possible
_____ *(Please sign that you read the cancellation policy and will adhere to it)*

Late Appointments
We do our best to ensure clients will be seen at their designated appointment time, therefore, we cannot give extra time if you are running late. (ex: if you are 10 minutes late, the appointment will only last 20 min.) _____ *(Please initial)*

Waiting Room
We aim to provide a comfortable waiting room for your family. In order to do so, families need to abide by the following rules.

We expect parents to teach their children quiet waiting, sharing, boundaries and kindness. Parents are required to supervise their children at **all** times. We encourage you to read or play with your child while waiting. Please *do not arrive more than 10 minutes prior* to scheduled session.

Children may not run, wander, climb, eat/drink (excludes babies nursing/bottle drinking).
We expect the following…

- parents to stay in waiting room (if not in session) until session is complete
- keep conversations low and child appropriate
- refrain from talking on cell phone
- turn off volume on electronic devices or use headphones
- treat others how you want to be treated
- clean up after your child

Please limit the amount of family members attending as we have multiple clients seen at one time and we need to ensure enough seating in our waiting room. If you have someone that can babysit siblings please have them stay home so we can attend therapy sessions to learn how to carryover skills at home. _____
(Please initial)

Education Play Station, Inc. Therapeutic Services
Billing Policies and Procedures

I hereby authorize Education Play Station, Inc., to furnish my insurance company(s) and/or designated attorneys, all information that said insurance company(s) or attorneys may request.

I hereby assign to Education Play Station, Inc., all payments which I receive from the insurance company for medical expenses relative to the service rendered, but not to exceed my indebtedness to EPS.

I understand that payments received from the insurance company(s) over and above any charges incurred, will be applied to my account as a credit to use against future co-payments or visit charges.

I understand that I am fully responsible to Education Play Station, Inc., for all charges not covered by the assignment of my insurance. Many non-covered items may include, but are not limited to: Medical Necessity, Developmental Delay, Ineligible for Coverage, or Non-Covered Benefit. The patient will be billed for any outstanding balances on their account after insurance has either rendered a payment and/or a final decision on the status of the open claim.

Payment plans are available through our billing department. In the event of non-payment, I understand that my account will be turned over to a collection agency for processing.

Informed Consent for Evaluations & Therapy

I give Education Play Station, Inc. my consent to perform speech, language, feeding, occupational, physical and/or cognitive evaluations &/or therapy with _____.
Client's Name

I understand my therapist may consult with other staff necessary.

Release of Information

I give permission for _____ (Medical/School/Treating Facility) to release all pertinent medical and/or social records of _____ (client's name) to Education Play Station, Inc. for the treating clinician to review prior to the evaluation or treatment.

I have read, fully understand, and will abide by the EPS Billing Policies and Procedures.

_____ _____/_____/_____
Parent/Guardian/Client Signature Date

_____ _____/_____/_____
Education Play Station, Inc. Employee Signature Date

Notice of Privacy Practices

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights, that I may contact the person listed on the provided packet. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified or changed in any way."

_____

Patient or Representative Name (please print)

_____ _____

Patient or Representative Signature Date

☐ Patient refused to sign

☐ Patient was unable to sign because _____

Patient Copy

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective Date of this Notice	**EDUCATION PLAYSTATION** **127 SUMMER STREET** **ADAIRSVILLE, GEORGIA** **30103** **770-877-9105**
Contact person – Megan Mingone	
Phone Number	

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's ***NOTICE OF PRIVACY PRACTICES***. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this ***NOTICE OF PRIVACY PRACTICES*** should it be amended, modified, or changed in any way."

_____
Patient or Representative Name (please print)

_____ _____
Patient or Representative Signature Date

☐ Patient refused to sign ☐ Patient was unable to sign because

_____

PRACTICE: PEEL OFF LABEL AND APPLY TO PATIENT CHART AS ACKNOWLEDGEMENT

Education PlayStation Inc.
Pediatric Case History

CLIENT INFORMATION

PATIENT NAME _____ PREFERRED NAME _____

ADDRESS _____ CITY/STATE/ZIP _____

PHONE: HOME _____ WORK _____ CELL _____

E-MAIL _____ WHO REFERRED YOU _____

DATE OF BIRTH _____/_____/_____ SEX _____ BIRTH WEIGHT _____ BIRTH HEIGHT _____

BIRTH HEAD CIRCUMFERENCE _____

NATIVE LANGUAGE(S) _____ LANGUAGES SPOKEN AT HOME (IF DIFFERENT) _____

FATHER'S NAME _____ FATHER'S AGE _____

FATHER'S OCCUPATION _____ EMPLOYER _____

HIGHEST EDUCATION LEVEL COMPLETED _____

MOTHER'S NAME _____ MOTHER'S AGE _____

MOTHER'S OCCUPATION _____ EMPLOYER _____

HIGHEST EDUCATION LEVEL COMPLETED _____

PARENT'S MARITAL STATUS ____MARRIED _____ DIVORCED _____ SEPARATED _____ WIDOWDED _____ SINGLE

FAMILY INFORMATION

NAMES AND AGES OF YOUR CHILD'S SIBLINGS_____

WHO IS CURRENTLY LIVING IN THE HOME WITH YOUR CHILD? _____

ANY SMOKERS IN THE HOME _____YES _____ NO PLEASE DESCRIBE ANY MAJOR CHANGES IN THE FAMILY

DURING THE LAST YEAR. _____

_____

FAMILY HISTORY

Illness/Disability	Family Member(s)	Illness/Disability	Family Member(s)
Hearing Loss	_____	Speech-language Problem	_____
Prematurity	_____	Blindness	_____
Malformation of the Head	_____	Educational Difficulties	_____
Low Birth Weight	_____	Seizures	_____
Mental Illness	_____	Delayed Motor Development	_____
Delayed Speech Development	_____	Drug Use	_____
Cleft Palate	_____	Sensory Integrative Dysfunction	_____

Insurance Information

Primary Insurance

Insurance Provider _____ Address _____

Insurance Phone # _____ Insured Relation to Patient _____

Insured Member's Name _____ D.O.B _____ Social Security # _____

Insured Place of work _____

Member ID # _____ Member Policy # _____

Medicaid ID # (if applicable) _____

Secondary Insurance

Insurance Provider _____ Address _____

Insurance Phone # _____ Insured Relation to Patient _____

Insured Member's Name _____ D.O.B _____ Social Security # _____

Insured Place of work _____

Member ID # _____ Member Policy # _____

I have verified the above information to be accurate and I authorize Education PlayStation Inc. to file my insurance. I understand that I am financially responsible for payment of all charges not covered by the insurance company.

Parent/Guardian Name (printed) _____

Parent/Guardian Name (signed) _____ Date _____

Witness (printed and signed) _____/_____ Date _____

Doctor Information

1. DOCTOR'S NAME _____ SPECIALTY _____

ADDRESS _____ CITY, STATE, ZIP _____

2. DOCTOR'S NAME _____ SPECIALTY _____

ADDRESS _____ CITY, STATE, ZIP _____

3. DOCTOR'S NAME _____ SPECIALTY _____

ADDRESS _____ CITY, STATE, ZIP _____

4. DOCTOR'S NAME _____ SPECIALTY _____

ADDRESS _____ CITY, STATE, ZIP _____

5. DOCTOR'S NAME _____ SPECIALTY _____

ADDRESS _____ CITY, STATE, ZIP _____

6. DOCTOR'S NAME _____ SPECIALTY _____

ADDRESS _____ CITY, STATE, ZIP _____

Medical Records Release

The following agreement is completely optional. If you agree, it will help Education Play Station Inc. as well as its colleagues, to work together in providing the best possible care for your child.

By signing, I hereby authorize Education Play Station Inc. to release and/or obtain medical records pertaining to my child _____with regards to any of the above doctors.
Print Child's First/Last Name

_____ _____ _____
Print Parent/Guardian Name Parent/Guardian Signature Date

School Information

Please provide information regarding all schools that your child has attended.

1. SCHOOL NAME _____ TEACHER(S) _____

ADDRESS _____ CITY, STATE, ZIP _____

2. SCHOOL NAME _____ TEACHER(S) _____

ADDRESS _____ CITY, STATE, ZIP _____

3. SCHOOL NAME _____ TEACHER(S) _____

ADDRESS _____ CITY, STATE, ZIP _____

4. SCHOOL NAME _____ TEACHER(S) _____

ADDRESS _____ CITY, STATE, ZIP _____

5. SCHOOL NAME _____ TEACHER(S) _____

ADDRESS _____ CITY, STATE, ZIP _____

6. SCHOOL NAME _____ TEACHER(S) _____

ADDRESS _____ CITY, STATE, ZIP _____

School Records Release

The following agreement is completely optional. If you agree, it will help Education Play Station Inc. as well as its colleagues, to work together in providing the best possible care for your child.

By signing, I hereby authorize Education Play Station Inc. to release and/or obtain school records pertaining to my child _____with regards to any of the above schools.
Print Child First/Last Name

_____ _____ _____
Print Parent/Guardian Name Parent/Guardian Signature Date

Current Questions and Concerns

Describe your concerns about your child's development: _____

_____

_____

When did you first notice your child's difficulty? _____

Describe any problems that appear to be a result of your child's difficulty:_____

_____

How do family members react to this problem? _____

_____

_____

What information do you hope to gain from this evaluation/therapy, and what specific questions or areas do you wish to address?

_____

_____

_____

Prenatal History

Age of mother at birth? _____

Please check any complications that apply to the birth of your child.

_____ Illnesses	_____ Medications	_____ Rh Incompatibility	_____ Drug Use
_____ Smoking	_____ Previous Miscarriages	_____ Trauma/Injuries	_____ Alcohol Use
_____ Excessive Weight Loss	_____ Excessive Weight Gain	_____ Diabetes	_____ Induced Labor
_____ Ruptured Membranes	_____ Use of Pitocin/Brethine	_____ Hospitalization/Bed Rest	_____ Other

Explain any items marked above: _____

_____

_____

_____

_____

_____

Birth History

My child was born at a gestational age of _____ weeks, via: _____Vaginal _____ C- Section

If the birth was vaginal, was it completed with: _____ Forceps _____Vacuum Extraction

If there were any complications at birth, how were they resolved? _____

_____

Medical History

Please check those that apply to your child:

_____ Low Birth Weight _____ Malformation of the Head _____ Hearing Loss _____ Cleft Lip

_____ Seizure Disorder _____ Malformation of the Neck _____ Vision Problems _____ Cleft Palate

_____ Educational Difficulties _____ Malformation of the Ears _____ P.E. Insertion Tubes _____ Asthma

_____ Allergies (Sinusitis, Food, etc.) _____ 3 or More Ear Infections _____ Surgeries _____ Other

Explain any items marked above: _____

_____

_____

Has your child ever been diagnosed with or attended therapy for the following:

_____ Speech / Language Problems _____ Physical Motor Problems _____ ADD / ADHD

_____ Feeding Problems _____ Vision Problems _____ Sensory Integrative Dysfunction

_____ Hearing Problems _____ Social Problems _____ Learning Disabilities

_____ Psychological Problems

Explain any items marked above: _____

_____

_____

Please describe reason for testing, evaluations, dates tested, results, and recommendations. Be specific as to any diagnosis that a professional has made regarding your child.

_____

_____

_____

_____

_____

Please list any medications (including dosage) that your child has been prescribed:

_____

_____

Oral Motor / Feeding History

Please check any that apply:

_____ Difficulty sucking or nursing

_____ Regurgitation of liquids or solids through the nose

_____ Difficulty chewing or swallowing meats

_____ Choking / Gagging

_____ Reflux

_____ Picky eater / Texture preference

_____ Difficulty gaining weight

_____ Excessive length of time required to drink bottle

_____ Difficulty transitioning from bottle to baby food

_____ Difficulty transitioning from pureed textured food

_____ History of aspiration

_____ Tube feeding (NG, OG, or G-tube)

_____ Excessive drooling

_____ Mouth Breather

If you checked Choking/Gagging, which foods cause your child this problem? _____

_____

If your child has food/texture preferences, what foods/textures are preferred? _____

_____

Describe any feeding problems your child experienced during the first three months of life: _____

_____

_____

Describe any feeding problems your child currently experiences: _____

_____

Speech and Language Development

Please indicate the age (in months) when your child first demonstrated the following:

Behavior	Age	Behavior	Age
Cooing, Pleasure Sounds	_____	Babbling (ba-ba, da-da, etc.)	_____
Jargon (talking own special language)	_____	Single Words	_____
Phrases	_____		

What is the primary method(s) your child uses for letting you now what he/she wants?

_____ Looking at Objects _____ Pointing / Gestures _____ Vocalizing / Grunting _____ Crying

_____ Physical Manipulation _____ Single Words _____ 2-3 Word Combinations _____ Sentences

Which of the following best describes your child's speech?

_____ Easy to understand _____ Difficult for parents to understand

_____ Almost never understood by others _____ Difficult for others to understand

_____ Different from other children of the same age

Is your child aware of his / her communication difficulties? _____ Yes _____ No

If yes, how does this impact your child's social / emotional status? _____

_____

Does your child have difficulty produce certain sounds? _____ Yes _____ No

If yes, which ones? _____

Does your child "get stuck" when attempting to say a word? _____ Yes _____ No

Do you have concerns about your child's voice? _____ Yes _____ No

Does your child stutter? _____ Yes _____ No

Which of the following do you think your child understands?

_____ His / Her own name _____ Family Names _____ Names of Body Parts _____ Names of Objects

_____ Simple Directions _____ Complex Directions _____ Conversational Speech

Motor Development

At approximately what age (in months) did you child achieve the following milestones?

Behavior	Age	Behavior	Age	Behavior	Age
Head Support	_____	Sitting Alone	_____	Crawling	_____
Standing Alone	_____	Walking Alone	_____	Eating with a spoon	_____
Undressing Self	_____	Potty Trained	_____		

Is your child overly awkward or clumsy? _____ Yes _____ No

Does your child display a hand preference? _____ Yes _____ No If so, which hand? _____

Social / Emotional Development

Please check any behaviors that describe your child:

_____ Overly Active _____ Overly Quiet _____ Defiant

_____ Excessive Tantrums _____ Destructive _____ Easily controlled / Passive

_____ Difficulty separating from parents _____ Very Shy _____ Dependent upon routines

_____ Perfectionist _____ Difficulty with transitions _____ Insists on carrying specific items

_____ Thumb-sucking _____ Nervous _____ Reluctant to try new things

_____ Friendly/Outgoing _____ Plays well with other children _____ Prefers older children

_____ Interrupted/Unusual sleep habits _____ Interrupted/Unusual eating habits _____ Prefers younger children

Describe any discipline problems you have with your child: _____

_____

Describe any evaluation or therapy for behavior or emotional problems your child has participated in: _____

_____

_____

Play Behaviors

Please check any play behaviors that describe your child:

_____ Putting toys in mouth _____ Shaking toys _____ Throwing toys _____ Pretend Play

_____ Acting out familiar routines _____ Banging toys together _____ Looking at books _____ Games with rules

_____ Appropriate use of objects _____ Pushing/pulling toys _____ Rough & tumble play _____ Role playing

What is the average length of time your child will stay playing one activity? _____

What activities seem to hold your child's attention for the longest period of time? _____

_____

What activities seem to hold your child's attention for the shortest period of time? _____

_____

Is your child distracted easily by any of the following?

_____ Visual stimuli _____ Auditory stimuli _____ Other people in the room _____ Nearby activities

With whom does your child play?

_____ Mother _____ Father _____ Brother/sister _____ Other child _____ Other adult _____ Self

List some of your child's favorite toys, activities, TV shows, and videos: _____

_____

Sensory History

Past or present consistent fussing or dislike of positions or activities:

_____

_____

Presently, why does your child cry? _____

How long does it take for your child to calm down after crying and what typically helps him/ her calm?

_____

_____

Was your child an irritable, happy, or passive baby?_____

Did your child sleep and eat well as a baby? _____

How long does your child sleep at night presently?_____

Does your child take naps during the day? _____

Does your child awake at night or have difficulty falling asleep or waking up? _____

_____

How does your child typically move from place to place: carried crawls walks stroller or other equipment:

_____

Explain any motor problems or concerns: _____

_____

_____

_____

Do you have any concerns about your child's vision or hearing: _____

_____

_____

_____

Sensory History Cont.

Please circle items if your response is for yes to the following questions:
Does your child: -play with interactive toys well -problem solve appropriately -recognize name -write name legibly -sing ABC song -identify all upper and lower case letters -follow directions appropriately -respond to limit setting /boundaries -know basic body parts -recite address/ phone #

Does your child seem sensitive to: -having face washed -hair washing -cutting /trimming nails -tooth brushing -movement or being tossed in the air -certain fabrics or tags in clothing -loud noises -being touched -busy/ crowded environments -change in his/ her routine -getting hands dirty -lights/ sunlight -play equipment at the park -being barefoot on textured surfaces (grass/ sand) -particular temperatures/ textures/ tastes of foods -being tickled -being touched unexpectedly
-Other:_____

Is your child: -unaware of touch at times -overly messy -frequently bumps into obstacles -frequently in motion -difficulty sitting still -excessively touching objects -displays a high tolerance to pain -craves tumbling or wrestling -hums, sings softly, "self-talks" through tasks -plays roughly with objects without ability to be gentle -takes big risks / is thrill seeker at playground -accident prone
-Other: _____

Does your child exhibit any unusual behaviors: -head banging -biting -looking intently at lights -repetitive behaviors of rocking, jumping, or spinning -mouthing/ licking -unusual fears -overly emotional or irritable -does not respond well to new or unfamiliar situations -aggressive behaviors -impulsive behaviors -unsafe behaviors -poor attention -minimal acknowledgement of others -difficulty playing by self/ entertaining self -isolates self
Other:_____

Does your child: -confuse L /R -difficulty coloring within the lines -difficulty learning to tell time or sequencing the months of the year -walking up/ down steps or uneven surfaces -difficulty with puzzles -completing tasks requiring good timing and speed (catching / hitting ball) -gets lost easily -handwriting difficulties -immature ability to draw a person -keeps eyes close to work -reverses letters/ numbers - stands too close to people -use two hands equally rather than showing a hand dominance -appear stiff -use awkward movements -poorly places paper with drawing or writing -avoids activities that require balance -avoids lifting heavy objects /or heavy work activities -clumsy with frequent bumping into objects -changing body positions without extra help or awkwardness -difficulty grasping marker/ pencil/ scissors -use short bursts of quick movements verses moving slowly with good control -difficulty sustaining good sitting posture, etc. tendency to "W" sit or prop self up
-Other:_____

Do you have any concerns about your child's ability to feed himself/ herself or ability to participate in meal time routines? Please

explain. _____

_____

Do you have any concerns about your child's ability to dress himself/ herself? Please explain.

_____

_____

Do you have any concerns about your child's ability to perform grooming and hygiene tasks? Please explain.

_____

_____

What toy, activity or daily routine is the most frustrating for your child presently?

_____

_____

Hearing History

Do you suspect your child has a hearing problem? _____ Yes _____ No Since what age have you suspected this? _____

Has your child's hearing: _____ Remained stable _____ Fluctuated _____ Progressively worsened

Has your hearing ever been tested? _____ Yes _____ No

If yes, Where? _____ When? _____ By Whom? _____

What were the results / recommendations? _____

_____

_____

Does your child have a hearing implant? _____ Yes _____ No

If yes, Where? _____ When? _____ By Whom? _____

Is the loss in one or both ears? _____ If one ear, which ear? _____ What is the level of loss and what were the results / recommendations? _____

_____

_____

Has your child ever been diagnosed with an auditory processing disorder? _____ Yes _____ No

If yes, Where? _____ When? _____ By Whom? _____

What were the results / recommendations? _____

_____

_____

Do you question your child's ability to understand directions or conversation? _____ Yes _____ No

If yes, what behaviors lead you to suspect this? _____

_____

_____

Listening Habits

Please place a check in the column that best describes your child's ability to hear in the following situations:

Situation	No Difficulty	Some Difficulty	Poor
Talking on the telephone	☐	☐	☐
Listening to radio / TV	☐	☐	☐
Listening in one-on-one conversations	☐	☐	☐
Listening in group conversations	☐	☐	☐
Hearing a message in a quiet environment	☐	☐	☐
Hearing a message in a noisy environment	☐	☐	☐
Ability to locate the direction of a sound	☐	☐	☐

Has your child ever worn: _____ Hearing aid (s) _____ FM system

If yes, which ear (s) are the aids worn? _____ Right _____ Left

When was the aid first fitted? _____ How old is/are the aids? _____

How long does your child wear the hearing aid(s) every day? _____

Do you feel your child benefit from the amplification? Please explain. _____

_____

_____

Has your child ever received Occupational Therapy, Speech-Language Therapy, and/or Physical Therapy? _____ Yes _____ No

If yes, what services were rendered? When? By whom? _____

_____

_____

Educational History

Does your child attend school for: _____ Full Days _____ Half Days How many times per week? _____

What type of classroom is your child in? _____ Traditional _____ Open Classroom _____ Transdisciplinary ____ Special Needs

Does your child have an Individual Education Plan (IEP)? _____ Yes _____ No

Does your child exhibit any learning style preference? _____ Auditory _____ Visual _____Tactile

Has your child's development interfered with his/her school performance? _____ Yes _____ No

If yes, please explain. _____

Have teachers expressed any concerns about your child's classroom performance? _____ Yes _____ No

If yes, please explain. _____

Miscellaneous Questions

Has your child been involved in a car accident within the past 5 years? If yes, please describe injuries, surgeries, hospitalizations, and results of tests. _____

_____

_____

If head trauma was experienced, please describe symptoms and recovery._____

_____

_____

Has your child ever had extremely painful headaches? If yes, please give description and frequency. _____

_____

Has your child ever had a seizure, brain bleed, or blood clot? If yes, please describe the circumstances, including the date and your treatment plan. _____

_____

Social/Vocational Needs

Please check any additional services you or your child may need now or in the next 6 months.

_____ Transportation to Therapy

_____ Transportation to Doctor Visits

_____ Transportation to Grocery and Public Venues

_____ Physical or Occupation Therapy

_____ Financial Assistance

_____ Counseling

_____ Job Training

_____ Clothing or Food Assistance

Please list any other concerns that you may have that are not listed above. _____

_____

_____

_____

Questions / Comments

If you have any specific questions or comments for us at Education PlayStation Inc., please feel free to write them below.

_____

_____

_____