CHERRY children's therapy
physical · occupational · speech
2000 East Matthews
Jonesboro, Arkansas
(870)336-3106 phone
(870)345-7214 fax

NEW PATIENT INTAKE FORM

PERSONAL INFORMATION

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

Age: _____ Male: _____ Female: _____ Primary Care/Pediatrician: _____

Legal Guardian: _____ **Legal Guardian**: _____

DOB: _____ DOB: _____

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

Email: _____ Email: _____

Physical Address: _____ Physical Address: _____

City, State, Zip: _____ City, State, Zip: _____

Mailing Address: _____ Mailing Address: _____

City, State, Zip: _____ City, State, Zip: _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Who referred you to our office? _____

Who does the child reside 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: _____

INSURANCE INFORMATION (please fill out ALL areas)

Primary Insurance: _____ Secondary Insurance: _____

Policy Number: _____ Policy Number: _____

Group Number: _____ Group Number: _____

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

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

Please **initial** the following statement: _____ **I <u>DO NOT</u> HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAT THE ABOVE MENTIONED.**

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EMERGENCY MEDICAL RELEASE

In the event medical attention is required for your child while the premises of Cherry Children's Therapy, we need your authorization to implement treatment. Please read and sign the statement below.

As legal guardian of _____, I give my permission for Cherry Children's Therapy to contact emergency personnel in the event of a medical emergency.

_____ _____

Parent/Legal Guardian Signature **Date**

EMERGENCY CONTACT

NAME: _____ **PHONE:** _____

RELATIONSHIP: _____

MEDICATION/ALLERGIES/CONDITIONS

Medications (Include prescription drugs, over the counter meds, vitamins, and homeopathic medications):

_____

Allergies/Reactions:

_____

Diagnoses (Any known medical diagnosis or medical condition, with dates of diagnosis if known):

_____

PHOTO PERMISSION

Please **initial** the following OPTIONAL statements:

_____ I give permission for photos/videos of my child to be used for the purposes of treatment, education, and documentation.

_____ I give permission for photos/video of my child to be used for advertising, brochure, and/or webspace.

TECHNOLOGY PERMISSION

Please **initial** the following **OPTIONAL** statements:

_____ EMAIL**:** I give permission to Cherry Children's Therapy to correspond with my child's legal guardians and care team via e-mail regarding treatment, documentation, and home programming. I understand that Cherry Children's Therapy e-mail is encrypted internally; however, once an email is sent externally, correspondence may potentially be intercepted by an outside party.

_____ **TEXT:** I authorize Cherry Children's Therapy to send text messages to my cell phone related to my child's therapy. I understand that communication via text message is not secure and may potentially be intercepted by a third party. I understand that standard data and text messaging rates will apply to any messages received from CHERRY CHILDREN'S THERAPY. I agree not to hold CHERRY CHILDREN'S THERAPY liable for any electronic messaging charges or fees generated by this service. I understand

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that CHERRY CHILDREN'S THERAPY text messages to my cell phone are not secure and potentially could be intercepted by an outside party.

AUTHORIZATION AND CONSENT FOR EVALUATION, TREATMENT, AND OPERATIONS:
Please **initial** the following statements:

_____I hereby give Cherry Children's Therapy Pediatric Therapy 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 Cherry Children's Therapy 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.

_____ _____

Parent/Legal Guardian Signature **Date**

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

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.

_____ _____

Parent/Legal Guardian Signature **Date**

TELETHERAPY CONSENT
If yes, please **initial** the following to give your consent.

Email for Teletherapy: _____

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_____ I give consent for my child to receive speech, occupational, and/or physical therapy via synchronous teletherapy when indicated.

_____ I agree to have a telemedicine facilitator (e.g., parent, guardian, or caregiver) present for teletherapy sessions. The telemedicine facilitator agrees to become competent with the telemedicine technology with training from my child's therapist and will assist my child in understanding and using this technology at the direction of my therapist. The facilitator will be on the premises and physically present if appropriate.

_____ _____

Parent/Legal Guardian Signature **Date**

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List the names of the programs/people that work with your child outside of Cherry Children's Therapy.

Service	Practice/School Name	Provider Name	Last Seen
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 Cherry Children's Therapy.

_____ _____

Parent/Legal Guardian Signature **Date**

****If your child has an IEP through his/her school, please bring us a copy for our records.**If your child has a neuropsych evaluation or any additional testing, please bring us a copy for our records.****

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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

Child's Name: _____ Nickname? _____ DOB: _____

Current concerns: _____

What are your primary goals for therapy?

_____

Has your child previously received occupational, physical, or speech therapy? To address what concerns? Please include where, when, and for how long:

_____

Is your child currently receiving any of these therapy services? Please list providers, locations, and days/times:

_____

Pregnancy & Delivery

Did the child's mother have any illnesses or complications during pregnancy or delivery? Please describe:

_____

Was your child premature? YES NO

Born at how many weeks gestation: _____ Birth Weight: _____

Did your child require any medical procedures before, during, or after birth? Please describe:

_____

Developmental History

Please indicate at what **age** each major milestone was reached:

Sitting up by self: _____ Crawling: _____ Walking: _____

First word: _____ Two words together: _____

What was their first word? _____ What was their first phrase? _____

When did you first become concerned about your child's development?

_____

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Feeding

Did your child have any feeding problems as an infant? Please describe:

_____

Was your child bottle fed or breast fed and for how long? _____

Did your child have any colic or reflux issues? _____

Describe your child's current eating habits and typical intake:

_____

Medical History

Please describe illnesses, hospitalizations, or surgeries that your child has had and when they occurred:

_____

Is there a family history of speech-language or other developmental delays?

_____

Has your child had a neuropsychological evaluation? YES NO

If yes, date of most recent evaluation: _____ Name of neuropsychologist: _____

Social History & Living Situation

Please describe your child's living situation (and any recent changes):

_____

Siblings' names and ages: _____

If your child was adopted, please answer the following questions:

Age of adoption: _____ Is your child aware of adoption? YES NO

Previous home experiences prior to adoption: _____

Educational History

Grade: _____ Name of school: _____ Teacher: _____

What kind of classroom (e.g., regular ed, special ed, life skills, pull-outs, etc.): _____
Does your child have an IEP? YES NO
What services does your child receive at school through the IEP? _____

Names of any school therapists? _____

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Hearing & Vision

Has your child had his/her hearing tested? When? What were the results? _____

Has your child had any ear infections? Please list number if known: _____

Did your child ever have tubes placed in his/her ears? When? _____

Has your child had his/her vision tested? What were the results? _____

Does your child wear glasses or hearing aids? For what condition? _____

What is the primary language spoken in the home? _____

Personal Information

Please describe your child's personality:

How do you handle discipline issues at home?

Does your child have tantrums? YES NO How often? _____ How does your child handle changes and variation in routine?

How much screen time does your child get (i.e., tablets, smart phones, computer, TV, etc.)?

What games, activities, toys does your child enjoy?

Describe how your child interacts with other children:

Describe your child's sleeping habits/patterns:

Briefly describe a typical day for your family, especially this child (feel free to use the back of this paper, if needed):

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PATIENT AGREEMENT

Cherry Children's Therapy 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 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.

ARKANSAS MEDICAID RECIPIENTS:

Arkansas 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.

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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 Cherry Children's 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 (870) 336-3106.

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 (870) 336-3106. 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 Cherry Children's Therapy 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 Signature **Date**

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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 Cherry Children's Therapy 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!

Please **initial** the following statements:

_____ 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 give Cherry Children's permission to submit bills directly to the insurance carrier.

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

_____ _____

Parent/Legal Guardian Signature **Date**

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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.

Please review and initial all statements below:

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

_____ 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. **

_____ 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. **

_____ 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. **

_____ 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.

_____ 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 calculate attendance quarterly and, as a courtesy, will notify you if your percentage drops below the required 80%.

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/Legal Guardian Signature **Date**

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CLINIC ETIQUETTE

Once again, we welcome you to Cherry Children's 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 Cherry Children's Therapy 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.

Please note the following clinic etiquette expectations:

- Do not enter the treatment space without a clinic escort.
- Accompany all younger children and those needing assistance or supervision to the restroom; this includes using the restroom for hand washing.
- If you have children in diapers or pull-ups, please bring a diaper bag to therapy.
- Please be mindful of the content discussed in your conversations (phone or in-person) or viewed on your electronic devices while in the clinic. Please only discuss topics or select websites, videos, music, etc. which are appropriate to discuss/view in the presence of children.
- Please do not ask therapists about other clients or families at the clinic. In order to comply with HIPAA, we cannot answer these questions.
- 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.

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

- Begin and end your appointments in a timely manner.
- Inform you of the goals targeted and the progress made during each session.
- Provide strategies and ways for you to address goals at home to increase carryover.
- Assist you in any way we can, such as brainstorming ideas to help make your family's life easier at home or talking with school therapists, etc.
- Keep anything you share with us confidential.
- Provide the best therapy we possibly can.
- Receive courteous and friendly help when scheduling appointments or dealing with billing questions.

If you have any questions about the above information, please do not 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/Legal Guardian Signature **Date**

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 CHERRY CHILDREN'S THERAPY 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 CHERRY CHILDREN'S THERAPY 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 CHERRY CHILDREN'S THERAPY; 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.

- **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.

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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.

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.

Settings, Hours, and Days of Service:

Therapy is provided in an outpatient therapy setting at Cherry Children's Therapy, 2000 East Matthews Ave., Jonesboro, AR 72401. In general, therapy services are provided between the hours of 8 AM and 5 PM, Monday through Friday.