THE CARRUTH CENTER
AT THE PARISH SCHOOL

Music Therapy
2016-2017
Intake Packet

- **Case History**
- **Authorization for Medical Attention**
- **Consent for Treatment**
- **Music Therapy Payment Contract & Authorization**
- **Carruth Center Policies**
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- **Music Therapy Assessment Profile**
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THE CARRUTH CENTER
AT THE PARISH SCHOOL

Case History

Date:_____ Information provided by:_____

Child's Name:_____
First Middle Last Name Called

Address:_____

Home Telephone Number:_____

Birth Date:_____Age:_____Gender: ☐ Male ☐ Female

Who has legal custody of this child?_____
_____

Is this child adopted?_____At what age?_____Is he/she aware of this?_____

Father: _____Date of Birth:_____

Home Address:_____
(if different) City State Zip Code

Contact Numbers: Home_____Work_____Cell#:_____

Email Address: _____

Marital Status:_____
married to child's mother (biological or adoptive), single, separated, divorced, widowed, remarried
PLEASE NOTE IF YOU ARE DIVORCED WE WILL NEED A COPY OF YOUR DIVORCE DECREE

Occupation:_____Place of Occupation:_____

Business Address:_____

Education/Highest Degree:_____

Mother: _____Date of Birth:_____

Home Address:_____
(if different) City State Zip Code

Contact Numbers: Home_____Work_____Cell#:_____

Email Address: _____

Marital Status:_____
married to child's father (biological or adoptive), single, divorced, widowed, remarried

Occupation:_____Place of Occupation:_____

Business Address:_____

Education/Highest Degree:_____

Please list the occupants of your child's:

Household 1:_____ **Household 2:**_____

Name	Age	Relationship to child	Name	Age	Relationship to child

Is any language other than English spoken in the home? _____Which?_____

Who referred you to The Carruth Center?_____

FAMILY HEALTH HISTORY, MENTAL ILLNESS, AND/OR DEVELOPMENTAL PROBLEMS:

Please check Yes or No for each of the medical conditions below which apply to a family member, then list relation to the right (e.g., mother, brother, paternal grandfather, maternal uncle, etc.)

Yes	*No*		*Yes*	*No*	
☐	☐	Thyroid_____	☐	☐	Kidney Disease _____
☐	☐	Heart Disease _____	☐	☐	Cancer _____
☐	☐	High Blood Pressure _____	☐	☐	Sudden Death _____
☐	☐	Vision Problems _____	☐	☐	Hearing Problems _____
☐	☐	Seizures _____	☐	☐	Cerebral Palsy _____
☐	☐	Birth Defects _____	☐	☐	Arthritis _____
☐	☐	Mental Retardation/Down's Syndrome _____	☐	☐	Diabetes _____

Please list any other diseases that run in the family:

_____

_____

Yes	*No*		*Yes*	*No*	
☐	☐	Depression _____	☐	☐	Bipolar Disorder _____
☐	☐	Nervous Breakdown _____	☐	☐	Autism/PDD _____
☐	☐	Emotional Problems _____	☐	☐	Speech Problems/Delays _____
☐	☐	Delinquency Problems _____	☐	☐	Eating Problems (anorexia/bulimia) _____
☐	☐	Substance Abuse _____	☐	☐	Anxiety _____
☐	☐	Alcoholism _____	☐	☐	Post-partum Depression _____
☐	☐	Bed Wetting after 5 yr. _____	☐	☐	Obsessive Compulsive Disorder _____
☐	☐	Hyperactivity/ADHD _____	☐	☐	Phobias _____
☐	☐	Schizophrenia _____	☐	☐	Other: Please specify _____
☐	☐	Learning Problems: Please specify _____			_____

CURRENT CONCERNS:

Please check below if you have any concerns about your child in these areas:

☐ Short Attention Span	☐ Attention seeking	☐ Distractibility
☐ Impulsivity	☐ Hyperactivity	☐ Avoidance
☐ Low frustration tolerance	☐ Noncompliance	☐ Anxiety
☐ Oppositional behavior	☐ Social Isolation	☐ Low self-esteem
☐ Aggression	☐ Lying	☐ Awareness of differences
☐ Difficulties with transitions	☐ Self-stimming	☐ Difficulties separating

Please list any additional concerns about your child: _____

_____

_____

When did these problems begin? _____

PRE AND PERI-NATAL HISTORY:

Was this a planned pregnancy: ☐ Yes ☐ No Fertility? _____

MEDICAL HISTORY DURING PREGNANCY:

Please answer which of the following conditions may have occurred during this pregnancy and explain in the space below:

Yes	*No*		*Yes*	*No*	
☐	☐	Edema (swelling of the hands and feet)	☐	☐	Epilepsy (Seizure)
☐	☐	Vaginal Bleeding	☐	☐	Infections (colds, flu, urinary tract, rubella)
☐	☐	Toxemia	☐	☐	Other Illnesses
☐	☐	High Blood Pressure	☐	☐	Tobacco/Alcohol/Controlled Substance use
☐	☐	X-ray studies			
☐	☐	Hospitalization			Frequency:_____
☐	☐	Fever	☐	☐	Injuries (specify):
☐	☐	Operations (specify): _____			_____
			☐	☐	Diabetes

Please explain all ***Yes*** answers: _____

_____

BIRTH HISTORY:

Length of Labor: _____

Type of Labor Onset:	☐ Induced	☐ Spontaneous	
Type of Birth:	☐ C/Section	☐ Vaginal	
Type of Anesthesia:	☐ Gas	☐ Spinal (epidural)	☐Local
Was the baby on time?	☐ Yes	☐ No	
If No, was he/she	☐ Early or	☐ Late, and by how many weeks? _____	

Age of Father at birth: _____ Age of Mother at birth: _____Number of Children Born: _____

Does either parent have children from previous relationships? If so, please list names & ages below:

Mother: _____

Father: _____

Problems during Labor:

Yes	*No*		*Yes*	*No*	
☐	☐	Toxemia/Eclampsia	☐	☐	Fetal Distress
☐	☐	Maternal Fever	☐	☐	Medications Used

How much did your child weigh? _____

Apgar Scores: _____

Check if any of the following problems occurred after the child's birth and explain in the space below:

Yes	*No*		*Yes*	*No*	
☐	☐	Trouble Breathing	☐	☐	Jaundice
☐	☐	Cord around the Neck	☐	☐	Poor Feeding
☐	☐	Fever	☐	☐	Vomiting
☐	☐	Hemorrhage (Bleeding) in Head	☐	☐	Floppy
☐	☐	Large Ventricles (Hydrocephalus)	☐	☐	Incubator Care
☐	☐	Cyanosis (turned blue)	☐	☐	Infection
☐	☐	Need for Ventilation/Oxygen	☐	☐	Other

Please explain all ***Yes*** answers:_____

_____

_____

How many days after birth was mother discharged from hospital? _____

How many days after birth was child discharged from hospital? _____

Previous Obstetrical History:

How many full-term pregnancies has mother had? _____

What were the dates? _____

Any abortions, miscarriages, or still births? _____

What were the dates? _____

<u>CHILD DEVELOPMENT:</u>

Was your child breast-fed? ☐ Yes ☐ No

Duration? _____

Describe the circumstances around stopping:

_____

Describe the weaning: _____

Was your child bottle-fed? ☐ Yes ☐ No

Duration? _____

Describe the circumstances around stopping:

_____

Please check any of the following that described your child as an infant:

☐ Fussy	☐ Sleeping problems	☐ Reflux
☐ Easy to soothe	☐ Feeding problems	☐ Failure to Thrive
☐ Difficult to soothe	☐ Cried excessively	☐ RSV
☐ Startled easily	☐ Colic	☐ Other_____

What are your child's sleeping arrangements?

☐ Room alone ☐ With sibling ☐ With parents ☐ With others

Does your child sleep in ☐ crib ☐ bed

Does he/she sleep through the night? ☐ Yes ☐ No

If not, how many times does he/she awaken at night? _____

For how long? _____

What helps him/her get back to sleep? _____

Did/Does your child have a special object (blanket, teddy bear, etc.)? ☐ Yes ☐ No

If yes, please describe _____

If yes, until what age? _____

Does he/she have any self-soothing behavior? ☐ Yes ☐ No

If yes, does he/she ☐ suck fingers/thumb ☐ use pacifier ☐ twirl hair

☐ other, please describe _____

Does your child exhibit any behaviors that you consider 'odd' or 'unusual'?_____

_____

_____

_____

How many hours of TV and/or video does your child watch each day? _____

What are his/her favorites? _____

Developmental Milestones: (age of mastery)

When did your child do the following (Please list specific age if possible):

	Early?	Late?	On time?	**AGE**
Smile	_____	_____	_____	_____
Laugh	_____	_____	_____	_____
Maintain eye gaze	_____	_____	_____	_____
Imitation	_____	_____	_____	_____
Gestures (pointing)	_____	_____	_____	_____
Roll over	_____	_____	_____	_____
Sit	_____	_____	_____	_____
Crawl	_____	_____	_____	_____
Stand	_____	_____	_____	_____
Walk	_____	_____	_____	_____
Wave Bye-Bye	_____	_____	_____	_____
Toilet Trained (day)	_____	_____	_____	_____
(night)	_____	_____	_____	_____
Babbling	_____	_____	_____	_____
Cooing	_____	_____	_____	_____

First words _____ _____ _____ _____
What were your child's first words? _____
When did your child put two words together? _____
Could you understand your child's speech by age 2? ☐ Yes ☐ No
Could others understand your child's speech by age 2? ☐ Yes ☐ No
Could your child speak in simple sentences by age 2? ☐ Yes ☐ No
How does your child typically communicate? ☐ Gesture ☐ Words ☐ Sentences
Does your child recite scripts from movies or TV? ☐ Yes ☐ No
Please describe any areas of concern (articulation, socialization, receptive language, expressive language, echolalia (parroting what is said)):_____
_____

When did your child:

	Early	Late	On time	AGE
Use writing utensils	_____	_____	_____	_____
Use eating utensils	_____	_____	_____	_____
Run smoothly	_____	_____	_____	_____
Snap	_____	_____	_____	_____
Button	_____	_____	_____	_____
Zip	_____	_____	_____	_____
Jump with 2 feet	_____	_____	_____	_____
Tie Shoes	_____	_____	_____	_____
Climb play equipment	_____	_____	_____	_____
Ride a bike: tricycle	_____	_____	_____	_____
Training wheels	_____	_____	_____	_____
Two-wheeler	_____	_____	_____	_____
Skip with coordination	_____	_____	_____	_____

Please describe any areas of concern (i.e., fine or gross motor, balance)_____

_____

Did your child do any head banging?_____At what age?_____

Is he/she left-handed or right-handed?_____Does he/she change from hand to hand?_____

MEDICAL HISTORY:

Child's Physician:_____Telephone #:_____

What major illnesses, hospitalizations, or operations has your child had? Please explain when the incident happened, what occurred, and how your child and each parent experienced this event.

_____

_____

_____

Do you have any concerns about your child's physical health? ☐ Yes ☐ No
If YES, please describe: _____

_____

_____

When was your child's last physical exam? _____ Where? _____

Please check which of the following your child has had and note the age, complications and frequency below:

Yes	No		Yes	No	
☐	☐	measles	☐	☐	mumps
☐	☐	chicken pox	☐	☐	pneumonia
☐	☐	whooping cough	☐	☐	viral infections
☐	☐	trauma (broken bones/stitches)	☐	☐	hospitalizations
☐	☐	concussions (age and treatment)	☐	☐	surgery
☐	☐	hearing problems	☐	☐	asthma
☐	☐	allergies	☐	☐	tremor
Yes	**No**		**Yes**	**No**	
☐	☐	meningitis (viral/bacterial)	☐	☐	RSV
☐	☐	persistent high fever	☐	☐	coma
☐	☐	convulsions	☐	☐	head trauma
☐	☐	loss of consciousness	☐	☐	pica (eating nonfood items, such as dirt or paper)
☐	☐	staring spells	☐	☐	bed wetting
☐	☐	accidental poisoning	☐	☐	stool soiling
☐	☐	vision problems	☐	☐	bowel problems
☐	☐	floppy	☐	☐	falls frequently
☐	☐	seizures	☐	☐	excessive vomiting
☐	☐	headaches	☐	☐	anemia
☐	☐	ear infections (how many?) _____	☐	☐	medication for convulsion
☐	☐	other infections:	☐	☐	medication for hyperactiviy
☐	☐	tics	☐	☐	medication for other illnesses (not including colds or ear infections)
☐	☐	other long term medical complaints/problems			

Please explain all **YES** answers, including age and treatment for each. _____

_____

_____

_____

_____

_____

_____

_____

Please list all medication you child has taken or is currently taking, and the dosage _____

_____

_____

_____

Has your child had a neurological examination? If so, where and when? What were the results? _____

_____

_____

Has your child had a psychological examination? If so, where and when? What were the results? _____

_____

SOCIAL/BEHAVIORAL HISTORY:

How does your child get along within the family circle?_____

_____

Does your child play well with siblings?_____

Does your child prefer to play alone?_____

Does your child prefer to play with ☐ older, ☐ younger or ☐ same age peers? (Please check)

Is your child aware of his/her difficulties?_____

What are your child's favorite activities?_____

_____

What methods of discipline are used?

☐ Rewards
☐ Time out
☐ Avoidance of child
☐ Other _____
☐ Verbal reprimands
☐ Removal of privileges
☐ Physical punishment

What are your child's reactions to discipline?_____

_____

Who is usually responsible for discipline?_____

How would you describe the effectiveness of parenting strategies in your home? _____

_____

_____

Please check all that apply to your child:

☐ Quiet
☐ Sensitive to change in routine
☐ Daydreams
☐ Irritable
☐ Sensitive to certain clothing/textures
☐ Dislikes being touched
☐ Resistant to change
☐ Unusual sexual behavior
☐ Happy
☐ Sensitive to loud noises
☐ Withdrawn
☐ Aggressive
☐ Unusual Fears
☐ Hyperactive
☐ Affectionate

Other:_____

Please describe the following characteristics in terms of whether the behavior never, sometimes or often occurs:

	Never	Sometimes	Often
Is your child active?	☐	☐	☐
Is your child loud and noisy?	☐	☐	☐
Does your child have difficulty making transitions?	☐	☐	☐
Is your child sensitive to light?	☐	☐	☐
Is your child sensitive to smells?	☐	☐	☐
Does your child cry easily?	☐	☐	☐
Is your child clingy?	☐	☐	☐
Can your child entertain him/herself?	☐	☐	☐
Does your child get angry easily?	☐	☐	☐
Does your child have temper-tantrums?	☐	☐	☐
	Never	Sometimes	Often
Is your child shy or slow to warm up to new adults?	☐	☐	☐
Is your child shy or slow to warm up to new children?	☐	☐	☐
Is your child physically cautious?	☐	☐	☐
Does your child take risks that endanger his/her safety?	☐	☐	☐
Is your child sad?	☐	☐	☐

If your child is aggressive, does he/she

☐ hit ☐ bite ☐ kick ☐ destroy property ☐ other? _____

EDUCATIONAL HISTORY:

Name of current school placement and grade/class:_____

In your child's classroom, what is the number of: Teachers_____

Assistants_____

Students _____

How is your child progressing?_____

Has he/she repeated any grades? If so, which?_____

With what area(s) has your child had particular difficulty?_____

_____

Has your child had special help through the school? If so, describe._____

_____

How does he/she child feel about school?_____

What are your child's favorite subject(s)?_____

Do you think your child's teacher likes him/her?_____

Does the teacher describe your child with any of the following comments (please check):

	Never	Sometimes	Often
Cannot follow directions	☐	☐	☐
Learns best using multi-sensory approach	☐	☐	☐
Seems to be daydreaming	☐	☐	☐
Learns best auditorily	☐	☐	☐
Cannot sit still	☐	☐	☐
Learns best visually	☐	☐	☐
Picks on other children	☐	☐	☐
Has a difficult time expressing his/her thoughts	☐	☐	☐
Is aggressive	☐	☐	☐
Doesn't seem to comprehend what's said	☐	☐	☐
Is sneaky	☐	☐	☐
Cannot complete tasks	☐	☐	☐

What do you feel are your child's strengths?_____

_____

Other Professionals:

List other professionals (speech/language pathologists, psychologists, psychiatrists, neurologists, tutors, educational diagnosticians, etc.) your child has seen in the past or is currently seeing:

Name	Telephone Number	Dates Under Care In The Past	Current Appointment Days & Times	Reason for seeing

Has your child ever been in any type of special educational/therapy program, and if so, how long?

	Where	Duration
☐ Early Childhood Intervention (ECI)		
☐ PPCD Class		
☐ Speech & Language Therapy		
☐ Physical Therapy		
☐ Occupational Therapy		
☐ Psychotherapy		
☐ Gifted and Talented		
☐ Other (please specify)		

Please use this area for any additional comments or concerns:

THE CARRUTH CENTER
AT THE PARISH SCHOOL

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

Child's Name (Print):_____ Date of Birth:_____

Mother's Home #:_____
Mother's Work #:_____
Mother's Cell #:_____

Father's Home #:_____
Father's Work #:_____
Father's Cell #:_____

In the event that we cannot be reached to make arrangements for emergency medical attention, we authorize Karen Dickerson, Clinical Director, or a designated staff member to take my child to:

Doctor _____
Address _____
_____
Phone # _____

Or to the nearest hospital, and we give our consent for any and all necessary treatment. In case of emergency treatment, please inform the medical staff that our child has the following allergies and that our child takes the following medication(s) on a daily basis (include dosage):

_____

_____

_____

Please list two (2) persons whom we may contact in the event of any emergency:

_____ _____ _____
Name Phone Relationship

_____ _____ _____
Name Phone Relationship

_____ _____
Mother's signature Father's signature

_____ _____
Child's Name & Birth date (please print) Date of signatures

THIS FORM MUST BE KEPT UPDATED AT ALL TIMES.

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Consent for Treatment

Client: _____ Date of Birth: _____

Parent/Guardian: _____ Relationship to Client:_____

I,_____ , hereby give consent for the above named child and/or myself to receive services at the Carruth Center of The Parish School. This consent is given until I give notice that these services are no longer requested or until Carruth Center of The Parish School professionals notify me these services will no longer be provided. I certify that I have legal responsibility for this child and am authorized to seek and consent treatment for him/her. I understand that all information provided to Carruth Center of The Parish School professionals is confidential and will generally be released to others only with my written consent. I understand that Carruth Center of The Parish School professionals are required to disclose confidential information without my consent in certain circumstances which includes, but is not limited to, 1) if is determined there is a probability of imminent physical injury by my child to himself/herself or other(s), or if there is a probability of immediate mental or emotional injury to my child 2) if the disclosure is required or authorized by law, legal proceedings, or court order 3) to qualified individuals, corporations, or governmental agencies involved in paying or collecting fees for mental or emotional health services for my child 4) to other professionals and personnel, under the direction of Carruth Center of Parish School professionals providing services to my child, who participate in the diagnosis, evaluation, or treatment of my child 5) a judicial or administrative proceeding brought against Carruth Center of The Parish School professionals by myself or my child 6) in the event it is believed my child is the victim of physical abuse, sexual abuse, or neglect, or if my child divulges information about the physical abuse, sexual abuse, or neglect of a child, elder, or disabled person.

The professionals rendering services through Carruth Center of The Parish School are dedicated to using established and empirically supported psychological, behavioral, and educational evaluation and intervention procedures to optimize the social, emotional, and cognitive development of each child. In the event a child presents as an immediate danger to himself/herself, others, or property, the least restrictive intervention shall be utilized to provide safety for the child, others, or property. While verbal mediation will be the primary intervention utilized, at times physical contact may be required to provide safety for the child, others, or property. At these times, a "therapeutic hold" will be used to help manage a child's behavior until verbal mediation can effectively be used to address the situation and/or until the child no longer presents as an immediate danger to himself/herself, others, or property.

My signature on this document indicates I have read the above information and have a clear understanding of the procedures, policies, and therapeutic interventions described. I have been given the opportunity to have my questions answered regarding the above-described information. I understand that I have the right to withdraw treatment for my child at any time.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Witness Date

THE CARRUTH CENTER
AT THE PARISH SCHOOL

PAYMENT CONTRACT & AUTHORIZATION
Individual Music Therapy

Client's (Childs) Name: _____

The fees for the individual Music Therapy sessions are invoiced on or around the **5th** day of the month following the last session of the previous month. Payment for these sessions will be direct debited from your account or charged to your credit card on or around the **15th** day of the following month (or the next business day), depending on the selection below and payment authorization information provided.

Music Therapy Evaluation with a report is $250.00.

Individual Music Therapy is $130.00 per hour session

_____ Please charge my **credit card** (complete the credit card authorization on following page).

_____ Please **direct debit** my account (complete the ACH direct debit on following page).

In consideration for the acceptance and enrollment of _____ in individual treatment, or group program, I (we) the undersigned parent(s), and/or guardian, or other endorser hereof, promise to pay to the order of Carruth Center, Inc. all applicable fees charged for services rendered due on/or before the fifteenth of the month following treatment. Outstanding balances may result in suspension of services until total account balance has been cleared. There will be a $20.00 service charge for NSF checks.

_____I understand that the form or payment on file must be kept current. To update your form of payment on file, submit a new "Payment Contract & Payment Authorization" form to the Carruth Center, Inc. Business Office before the 15th of the month.

_____I authorize the Carruth Center, Inc. to charge the agreed upon credit card or ACH debit on or around the 15th of each month for services provided during the previous months (generally on going individual services) OR on the dates specified in the payment option selected on the signed contract for services (generally group therapy).

_____I agree that if initial payment processing is declined for any reason, Carruth Center, Inc. may continue to process the payment against the card on a regular basis, until the payment is successfully processed and the balance is resolved. Reoccurring payment declines will result in payments being due at the time of service. In this circumstance acceptable form of payment would be exact cash or a credit card that can be successfully processed at the time of service.

_____I acknowledge and understand the cancellation, late arrival, and late pick-up policies. See Carruth Center Policies form.

See reverse side for payment authorization form
Carruth Center, Inc. must have a current form of payment on file for all clients.

THE CARRUTH CENTER
AT THE PARISH SCHOOL

PAYMENT CONTRACT & AUTHORIZATION

Client's (Childs) Name: _____

Credit Card Authorization

_____ Visa _____ MasterCard _____ American Express _____ Discover

Credit Card Number: _____

Expiration Date: _____ Card Security Code (CSC): _____

Name on Card: _____

Address: _____

_____

ZIP Code: _____

Phone Number: _____

ACH Direct Debit Authorization

_____ Checking Account _____ Savings Account

Depository Name _____ Branch _____

City _____ State _____ Zip _____

Routing Number _____ Account Number _____

_____I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. Law.

Attach a blank voided check

This Authorization is to remain in full force and effect until Carruth Center, Inc. has received written notification from me (I or either of us) of its termination in such time and in such manner as to afford Carruth Center, Inc. and DEPOSITORY a reasonable opportunity to act on it.

Print Name: _____

Date: _____ Signature: _____

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Carruth Center Policies

Client's (Childs) Name: _____

Please read carefully. **Both parents or guardians** are required to initial each line.

___ ___ **Clinic Visitation Policy:**

- Children must be accompanied by an adult in the lobby at all times.
- Please check in with Carruth Center, Inc. office before entering the therapy area. All parents and visitors must wear a visitor badge while in the Carruth Center, Inc. therapy area.
- Group observations must be scheduled through the Carruth Center, Inc. business office at least 24 hours in advance.

___ ___ **Cancellation Policy:**

The undersigned hereby acknowledges that failure to cancel a scheduled treatment session or a parent conference 24 hours in advance of the scheduled appointment will result in a 100% charge for the allocated session fee. Carruth Center, Inc. administration reserves the right to dismiss a client from therapy for inconsistent attendance. In addition, the undersigned hereby acknowledges that Carruth Center, Inc. reserves the right to withhold all test results and reports when professional fees are not paid as per above.

- **No show/no call cancellation**: The undersigned hereby acknowledges that failure to notify the treating clinician to cancel a scheduled treatment session will be considered a no show/no call appointment. We ask that all cancellations, not due to illness or a family emergency be made 24 hours in advance.
  A no show/no call appointment will result in a 100% charge for the allocated session fee.
- **Late Cancellation**: The undersigned hereby acknowledges that any cancellation, not due to illness or family emergency, that is made **less** than 24 hours in advance is considered a late cancellation. A late cancellation will result in a 100% charge for the allocated session fee.

THE CARRUTH CENTER
AT THE PARISH SCHOOL

___ ___ **Late Pick-up Policy:**

The undersigned hereby acknowledges that parents are expected to be in the Carruth Center, Inc. lobby or front porch area prior to the end of their child's therapy session. Carruth Center, Inc. late-pick up policy is as follows:

- Client families will be given 2 "passes" (no charge assessed) per fiscal year (August 1st - July 31st) for unexpected tardies not to exceed 5 minutes.
- Late pick-ups **BEYOND** 5 minutes **OR** post 2 "passes" will be charged per the quarter-hour at the standard individual therapy rate.
- Chronic tardiness may lead to parent being required to remain present on campus throughout therapy session.

Breakdown of Late Fees according to therapy discipline

Standard Speech, OT, Music Individual Therapy Sessions	**Standard Individual Therapy Rate ($130.00)**	**Standard Mental Health Individual Therapy Sessions**	**Standard Mental Health Individual Therapy Rate ($140.00)**
5-15 minutes	$32.50	5-15 minutes	$35.00
15-30 minutes	$65.00	15-30 minutes	$70.00
31-45 minutes	$97.50	31-45 minutes	$105.00
46 – 60 minutes	$130.00	46 – 60 minutes	$140.00

*standard mental health therapy hour is 45 minutes for children, and 50 minutes for adults)

- Late fees will be included in the monthly invoice. Failure to resolve fees with regularly scheduled, monthly payment processing, on or around the 15th of every month, will result in suspension of client services.
- Late pick up fees are not eligible for insurance reimbursement.

___ ___ **Late Start Policy:**

The undersigned hereby acknowledges that late arrivals will not be accommodated by extension of therapy time. Full session fee will apply to late arrivals. For example: If a client is 5 minutes late to their scheduled appointment time, the result will be a 30-minute session fee, even though it was only a 25-minute therapy session.

- Clients are encouraged to arrive to the Carruth Center, Inc. lobby 2 to 5 minutes prior to their scheduled session time.

THE CARRUTH CENTER
AT THE PARISH SCHOOL

___ ___ **Policy on Insurance:**

- Carruth Center, Inc. is a fee-for-service facility and families are responsible for all payments.
- Carruth Center, Inc. does not guarantee coverage and/or the ability to gain coverage of services. Coverage is determined by your individual policy.
- Carruth Center, Inc. is considered out-of-network, and therefore, we ask that families act as the liaison for any direct communication with their insurance companies.
- Carruth Center, Inc. does not submit claims on behalf of the client.
- Carruth Center, Inc. provides invoices and or services provided forms with necessary codes, clinician information, and clinic information for your convenience and ease of filing claims.
- Carruth Center, Inc. does not accept payment from insurance companies. All insurance checks issued to the Carruth Center, Inc. are returned to the insurance company with a request to issue payment to the insured. The insured is then notified by letter and copy of the check for their records.

Parent Name (Print): _____ Date: _____

Signature: _____

Parent Name (Print): _____ Date: _____

Signature: _____

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AUTHORIZATION FOR REQUEST/RELEASE OF INFORMATION

Child's Name: _____

I hereby authorize:

Randi Raizner, PhD.	_____ initial to consent
Carruth Center, Inc.	_____ initial to consent
The Parish School	_____ initial to consent

I hereby give permission to The Carruth Center for the following:

_____ In order to process a claim for benefits, I authorize the Carruth Center, to release to my insurance carrier any information regarding my child's medical history, symptoms, treatment, examination results, or diagnosis. Termination of consent must be submitted in writing.

Occupational Therapy REQUIRES Physician's name: _____

Below are listed the person(s), agencies and schools that the assigned individuals or company may contact:

	Name	Address	Telephone #	Fax #
1.	_____			
2.	_____			
3.	_____			

I understand any information obtained is strictly confidential and privileged.

_____ _____
Date Parent or Legal Guardian

A copy of this instrument is as valid as the original.

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Music Therapy Assessment Profile

Client's Name: _____ Sex: M F DOB:_____
Therapist's Name: Kate Wasserman, MT-BC Chronological Age: _____
Referring Individual:_____
Interviewee's Name: _____
Relationship to Client: _____ Date Completed: _____

Please complete this form by circling the appropriate response to each question (Yes or No). In the space provided, please briefly explain or provide details for each response.

General Information		
Does the child have a current diagnosis? Dx: Who gave this diagnosis and when?	Yes	No
Is the child on any medications? *Meds:*	Yes	No
Does the child have any allergies or sensitivities?	Yes	No
Are there any precautions I should take in working with the child? (i.e. seizures, biting, self-injurious behavior, etc.)	Yes	No
Does the child participate in any other therapies? *Therapies:*	Yes	No
Has the child had any previous musical experience or exposure?	Yes	No
Do you believe the child has any particular musical aptitude?	Yes	No
Are there any musicians in the child's immediate family? *Who?*	Yes	No
Have you noticed that the child has any musical preferences?	Yes	No
What are the primary reinforcers or motivators in the child's life (i.e. certain toys, activities, experiences, etc.)?		
What benefit do you anticipate from music therapy?		

Client Name: _____ Date: _____

Please circle the appropriate response to each question (Yes or No). Please offer detail to each question in the space provided, particularly if you circle a response in the shaded column.

Gross Motor		
Have you noticed that the child has any gross motor difficulties?	Yes	No
Is the child fully ambulatory?	No	Yes
Does the child require any physical assistance?	Yes	No
Does the child have full use of all of his/her limbs?	No	Yes

Fine Motor		
Have you noticed that the child has any fine motor difficulties?	Yes	No
Is the child able to perform fine motor tasks with both hands? (i.e. eat with utensils, button a button, hold a pencil)	No	Yes
Does the child frequently drop items or have difficulty holding objects?	Yes	No

Oral		
Does the child have any feeding issues?	Yes	No
Does the child have any respiratory issues?	Yes	No

Sensory		
Have you noticed that the child has any sensory issues?	Yes	No
Does the child resist physical support?	Yes	No
Does the child engage in any repetitive behaviors?	Yes	No
Does the child have any deficits in hearing, vision, or other senses?	Yes	No
Does the child have any sensitivities to or extreme preferences for particular sounds?	Yes	No
Is the child over-stimulated by sound, lights, or crowds?	Yes	No

Client Name: _____ Date: _____

Receptive Communication/Auditory Perception		
Has the child been diagnosed with any hearing difficulties? *If so, has an audiogram been done and what were results:*	Yes	No
Does the child have difficulty hearing sounds or understanding speech?	Yes	No
Does the child have a history of ear infections?	Yes	No
Does the child understand or react to what is being said to him/her?	No	Yes

Expressive Communication		
Have you noticed that the child has any speech or language difficulties?	Yes	No
Does the child communicate verbally? *If not, please indicate mode of communication:*	No	Yes
Do others easily understand the child?	Yes	No
Does the child have any idiosyncratic speech behaviors? *(babble/jargon, echolalia, scripted phrases, delayed or irregular meter)*	Yes	No

Cognitive		
Have you noticed that the child has any cognitive deficits or difficulties?	Yes	No
Does the child receive additional support in the educational setting? *In what academic areas/skills:*	Yes	No
Is the child in with same-age peers in their educational setting?	No	Yes

Emotional		
Have you noticed that the child has any emotional difficulties?	Yes	No
Does the child show emotions appropriately?	No	Yes
Does the child tantrum or get angry easily?	Yes	No
Has the child suffered any emotional trauma or recent change in life circumstances?	Yes	No

Client Name: _____ Date: _____

Social		
Have you noticed that the child has any social difficulties?	Yes	No
Does the child have any difficulty relating to family members?	Yes	No
Does the child have a social group of like-aged peers?	No	Yes
Does the child participate in conversation or play with others?	No	Yes
Does the child have any particular difficulties in school or in other social situations?	Yes	No

Is there anything we have not covered that you feel is important to know about the child?

_____

_____

_____

_____

_____

_____

Contact Information:

Please provide the best ways pursue follow-up communication regarding the client.

Phone Number: _____ (home/cell/work) Whose phone is this? _____

_____ (home/cell/work) Whose phone is this? _____

Email: _____ Whose email is this? _____

_____ Whose email is this? _____

THE CARRUTH CENTER
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Music Therapy Services
Schedule of Fees

- Music Therapy Evaluation (up to 2 hours *with* a report) $250.00
- Individual Session (60 minutes) $130.00
- Group Session (per hour) $ 80.00
- Parent Conference (30 minutes) $ 65.00