

Tender Ones Therapy Services  
2089 Teron Trace Suite 120  
Dacula, GA 30019  
Phone: 770-904-6009  
Fax: 770-904-2357

## PHYSICAL THERAPY INTENSIVE PROGRAM REGISTRATION FORM

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Thank you for choosing to register for the PT Intensive Therapy Program! This program consists of 3 hours of PT per day, 5 days per week, for 2- or 3- week sessions.

**ADDITIONAL SERVICES** – TOTS has many services that are offered **in addition to** the PT Intensive Therapy Program which can complement your child's program. Please choose the additional services that you would like your child to receive in addition to their primary intensive program.

- Occupational Therapy \_\_\_\_\_ days per week
- Speech Therapy \_\_\_\_\_ days per week
- Aquatic Therapy \_\_\_\_\_ days per week
- Occupational Feeding Therapy for limited diet, picky eater, sensory concerns \_\_\_\_\_ days per week
- Speech Feeding Therapy for dysphagia, swallowing, medical feeding issues \_\_\_\_\_ days per week.

### RESERVATION

My preferred month/year to attend is \_\_\_\_\_, if unavailable my second preference is \_\_\_\_\_ .

I would like a 2 week session \_\_\_\_\_ Total of 30 hours of Therapy

I would like a 3 week session \_\_\_\_\_ Total of 45 hours of Therapy

If your preferred sessions are not available our ITP coordinator will offer alternative sessions.

All scheduling is done through our ITP coordinator, Melanie Sudge, and she will be happy to work with you to schedule the most appropriate therapy sessions for your child. If you have private insurance, Melanie will verify your benefits, determine if authorization is needed and discuss insurance coverage. If your child has Georgia Medicaid she will coordinate with your present clinic regarding authorization through Medicaid.

## **DEPOSIT REQUIRED TO RESERVE SESSION**

In order to reserve your spot, you must provide a \$1000 reservation deposit for a two-week intensive and \$1500 for a three-week intensive. Once this is received your child will have their session reserved and your child will be assigned to a therapist whose schedule will be blocked off to accommodate your child's session.

This reservation deposit will go towards any out-of-pocket costs for your child's session such as co-pays that private insurance may apply. Once your child completes their intensive session and all dates of service have been paid by either private insurance or Medicaid and there is any balance remaining you will be refunded that amount.

Considering the extensive therapy time that we are assigning to your child's therapist it is imperative that you understand our cancellation policy.

## **LATE RESERVATION CANCELLATION / NO SHOW POLICY**

The intensive deposit is a reservation fee that is fully refundable if you cancel 30 days or more in advance of your child's scheduled session. For any scheduled day that is not cancelled prior than 30 days in advance there will be a late reservation cancellation fee charged of \$100 per day.

If you or your child becomes sick, this includes having to quarantine due to COVID prior to or during your child's session, and they are unable to physically attend we will offer two options for you in order to not charge the late reservation cancellation fee.

1) We will provide the intensive therapy session via Teletherapy - Our therapists have successfully been able to provide teletherapy from one day to an entire two-week session. This requires a facilitator with your child if the child is unable to follow directions or move independently on their own.

2) We will work with you to make up the time over the course of the remaining days of the reserved session.

If you are unable to commit to Teletherapy or to making up this time you will be charged the \$ 100 / day cancellation fee. Please be aware that Georgia Medicaid authorizes therapy by the month, therefore if your session is at the end of the month there is limited opportunity to make up the missed time and, in that situation, we would recommend teletherapy on the day your child was unable to physically come to the office.

No late reservation cancellation or no-show fee can be charged to private insurance or Medicaid.

By placing your name below, you agree and understand our reservation deposit policy and late cancellation /no show policy.

\_\_\_\_\_ Date: \_\_\_\_\_

Please contact Melanie with any questions at (770) 904-6009 ext.104 or by email at [melanie@tenderones.com](mailto:melanie@tenderones.com).

## **THERASUIT**

For those patients who will be using the Therasuit during the PT Intensive Therapy Program we will need a Letter of Medical Clearance turned in that is filled out by your child's physician. Below is a Letter of Medical Clearance that you may provide to your physician to state whether the child's hips are cleared to use the Therasuit. Children with more than 40 degrees subluxation of their hips should not wear the Therasuit. Children who are unable to wear the Therasuit will still benefit tremendously by participating in the Intensive Therapy Program. Please have your physician fax this form to TOTS.

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**Letter of Medical Clearance for wearing Therasuit**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Your patient will be participating in an intensive physical therapy program at our location. There are many unique forms of equipment that we may utilize during this program. One of them is the Therasuit®. The Therasuit® is a soft canvas suit with rubberized cords that are aligned to create a compressive load on the entire skeletal system. The combination of the arrangement of the cords and the load help to improve postural alignment, promotes strengthening, helps to integrate primitive reflexes, and facilitates proper activation of movement patterns.

The Therasuit® causes increased weight bearing throughout the joints of the body anywhere from 10-30 pounds. We are requesting that we have physician approval to utilize the Therasuit.

This child's hips are intact and/or have less than 40 degrees subluxation. I authorize that they may wear the Therasuit®:

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This child has more than 40 degrees subluxation of one or both of their hips and/or I do not authorize use of the Therasuit®

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_