Dear Parent/Caregiver:

Thank you for your interest in Easterseals services.

The fees for each evaluation are as follows:

Speech	$320.00
Occupational /Physical Therapy	$230.00
Counseling	$528.00
Applied Behavior Analysis Evaluation	$600.00
Feeding Evaluation	$357.00

If you would like to schedule an evaluation, please complete the enclosed forms and return to me at your earliest convenience:

- Client Registration Forms
- Medical History Forms
- Signed Informed Consent Form and Release of Information for Pediatrician (Additional consents for school or specialists are optional)
- Signed Financial Agreement.
- A copy of your insurance card (both front and back) - if you are unable to copy your card, please be sure to bring your card to your evaluation.

Once your completed forms are received, our Client Financial Services Department will verify your insurance benefits**.** You will receive a letter in the mail outlining the coverage information that was provided to us. **Please be aware the insurance verification we receive is not a guarantee of coverage by your insurance provider. We strongly advise that you also contact your insurance provider to verify coverage for the requested service. Please also be advised that co-pays are to be paid at the time of service.**

Once insurance verification has been completed, a scheduler will contact you to offer the first available appointment time to schedule the evaluation.

If you have any questions prior to your appointment, please do not hesitate to call or email me at the contact information provided below.

Thank you for the opportunity to serve your family. I look forward to receiving your information.

Sincerely,

Jennifer Simpson
Rehabilitation Coordinator
Easterseals Peoria
507 E. Armstrong
Peoria, IL, 61603
(p) 309-686-7755 x2202
(f) 309-686-7722
JSimpson@ci.easterseals.com

Cindy Frazier
Rehabilitation Coordinator
Easterseals Bloomington
2404 E. Empire
Bloomington, IL 61704
(p) 309-663-8275 x237
(f) 309-662-7872
CFrazier@ci.easterseals.com

Easterseals Central Illinois
Client Registration Form

CLIENT INFORMATION (Please Print)

Client's Legal Name: First _____ MI _____ Last Name _____

Preferred Name (Nickname): _____ Date of Birth: _____ ☐ Male ☐ Female

Mailing Address: _____ City/State/ZIP: _____

Physical Address:_____ City/State/ZIP: _____
(if different than mailing address)

PARENT/LEGAL GUARDIAN INFORMATION

Parent/Legal Guardian One:

☐ Mother ☐ Father ☐ DCFS ☐ Legal Guardian

☐ Other: _____ ☐ Child lives with: _____

Parenting Status: ☐ Natural ☐ Adoptive ☐ Foster

Full Name: _____

Address: _____

City/State/ZIP: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer:

Name: _____

Address: _____

City/State/ZIP: _____

Phone: _____

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other: _____

Parent/Legal Guardian Two:

☐ Mother ☐ Father ☐ DCFS ☐ Legal Guardian

☐ Other: _____ ☐ Child lives with: _____

Parenting Status: ☐ Natural ☐ Adoptive ☐ Foster

Full Name:_____

Address: _____

City/State/ZIP _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer:

Name_____

Address: _____

City/State/ZIP: _____

Phone: _____

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other:_____

EMERGENCY CONTACT or DCFS contact (other than listed above)

Full Name: _____ Home Phone: _____

Relationship to Client: _____ Alternate Phone: _____

ADDITIONAL INFORMATION

Providing this information below is essential in helping Easterseals apply for grants to fund our services. This information is confidential and will not be disclosed on an individual basis, but will only be used to provide consolidated information to organizations that can provide funding for our services.

Ethnicity:
- ☐ White, non-Hispanic
- ☐ Black/African American, non-Hispanic
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Other: _____

Do you speak English? ☐ Yes ☐ No If no, what language do you speak? _____

Do you need an interpreter? ☐ Yes ☐ No

Household Income:
- ☐ Less than $10,000
- ☐ $10,000-$19,999
- ☐ $20,000-$29,999
- ☐ $30,000-$39,999
- ☐ $40,000-$49,999
- ☐ $50,000-$59,999
- ☐ $60,000-$69,999
- ☐ $70,000-$79,999
- ☐ $80,000-$89,999
- ☐ $90,000-$99,999
- ☐ Over $100,000

How did you hear about us? (Check all that apply)

- ☐ Billboard
- ☐ Commercial
- ☐ Easterseals Employee
- ☐ Facebook
- ☐ Flyer
- ☐ Friend
- ☐ Instagram
- ☐ Insurance Company
- ☐ Internet
- ☐ Newspaper
- ☐ Physician
- ☐ Twitter
- ☐ Website
- ☐ Other: _____

Easterseals Central Illinois
Medical History

CLIENT INFORMATION (Please Print)

Client's Legal Name: First _____ MI _____ Last Name _____

CLIENT/PARENT CONCERNS

Parent/Caregiver: What do you want your child to do that he/she is unable to do?

Parent/Caregiver: What is your child doing that you would like to change?

Parent/Caregiver: What are the top two concerns that you would like therapy to help with?

Parent/Caregiver: What are some of your family's favorite things to do?

Client/Child: Is there anything you can't do that you would like to be able to do?

Client/Child: What are your favorite things? (Hobbies/Food/Toys/Etc...)

MEDICAL HISTORY

PRENATAL/BIRTH HISTORY

Pregnancy proceeded: ☐ Normally ☐ With complications ☐ Adopted/Foster, history not known

Prenatal care was: ☐ Received ☐ Not Received ☐ Unknown

Please indicate/describe complicating conditions:

☐ None/Unknown ☐ During pregnancy: _____

☐ During delivery: _____ ☐ After delivery: _____

Length of pregnancy: _____ Weeks Mother's age at time of birth: _____ Years

Birth Hospital: _____

Was your child transferred to another hospital?

☐ Yes ☐ No Name of Transferred hospital: _____ Length of stay:_____

Was your child admitted to the NICU?

☐ Yes ☐ No Length of stay in NICU:_____

Delivery was: ☐ Vaginal ☐ C-Section ☐ Emergency C-Section

Birth Weight: _____ lbs. _____ Oz. Birth Length: _____ Inches.

Medications during pregnancy (prescribed): _____

Other substances during pregnancy (alcohol/illegal drugs/tobacco): _____

MEDICAL HISTORY

Diagnosis if any: _____

PRIMARY CARE PHYSICIAN

Name: _____ Office Phone : _____

Please indicate if your child has a history or is currently being treated for any of the listed conditions:

- ☐ Alcohol/Illegal Drug Use
- ☐ Anemia
- ☐ Anoxic Brain Injury
- ☐ Arteriovenous Malformation (AVM)
- ☐ Asthma
- ☐ Cerebral Vascular Accident (CVA)
- ☐ Chronic Ear Infections
- ☐ Constipation
- ☐ Diarrhea
- ☐ Endocrine Related Problem (thyroid or other hormones)
- ☐ Exposure to Lead
- ☐ Feeding (specific difficulties)
- ☐ Fractures or Broken Bones
- ☐ Frequent Infections
- ☐ Gastro Esophageal Reflux (GERD)
- ☐ Genital/Urinary Problems
- ☐ Heart Disorder
- ☐ Muscular Disease
- ☐ Nausea, Vomiting
- ☐ Neurological Disorder
- ☐ Oxygen Dependent
- ☐ Poor Weight (Failure to Thrive)
- ☐ Psychiatric Disorders
- ☐ Seizure Disorder
- ☐ Sleep Problems
- ☐ Tobacco Use
- ☐ Traumatic Brian Injury (TBI)
- ☐ Other: _____
  _____

CURRENT MEDICATIONS

Medication	Prescribing Physician	Physician Phone Number	Purpose of Medication

Current vitamins, herbs, mineral, homeopathic supplements:

Does your child routinely take over the counter medications?

☐ Yes ☐ No If yes, please list:_____

_____

Allergies (include latex) Please list: _____

Are your child's immunizations up-to-date?

☐ Yes ☐ No If no, please explain: _____

_____

Hearing Testing:

- ☐ Never tested, no concerns
- ☐ Abnormal test results Date (mos./yr.): _____

Describe: _____

_____

- ☐ Never tested, have concerns

Describe concerns: _____

Vision Testing:

- ☐ Never tested, no concerns
- ☐ Abnormal test results Date (mos./yr.): _____

Describe: _____

_____

- ☐ Never tested, have concerns

Describe concerns: _____

DIAGNOSTIC TESTS

	Date	Specialist
Autism Diagnostic Evaluation		
EEG		
Genetic Testing		
Mobility Study/Emptying Scan		
MRI		
Upper/Lower GI		
X-Ray(include Hip/Spinal)		
Other:		

List any previous surgeries/hospitalizations:	Date:
1.	
2.	
3.	

CONTRAINDICATIONS/PRECAUTIONS: (Physician's prescription must include any precautions needed for treatment.)

Please indicate if your child has a history or is currently being treated:

☐ None ☐ Osteoporosis ☐ Shunts ☐ Vagus Nerve Stimulator

☐ Baclofen pump ☐ Seizure condition ☐ Tube feeding ☐ Other _____

ADDITIONAL INFORMATION

	Specialist	Date
Constraint Induced movement Therapy		
Botox		
Serial Casting		

	Specialist	Type	Date
Orthotics(braces)			
Assistive Technology/Equipment			
Other:			

SPEECH & LANGUAGE INFORMATION

Please check if your child is using the following to communicate:

☐ Jargon (babbling with intent, no real words) ☐ Phrases ☐ Words ☐ Sentences

Is your child's speech understandable?

☐ Yes ☐ No If yes, what type: _____

Does your child have/or use an Augmentative Communication Device?

☐ Yes ☐ No If yes, what type: _____

BEHAVIOR/SOCIAL INFORMATION

Has your child experienced a regression or loss of skills?

☐ Yes ☐ No If yes, please describe: _____

_____

Please check if your child consistently does the following:

☐ Makes eye contact when spoken to

☐ Shows negative response to being touched

☐ Enjoys movement like swinging or roughhousing

☐ Seems to have skills that are extremely advanced

☐ Independent in toileting

☐ Plays independently

☐ Plays with peers

☐ Walks independently to get around in the community

☐ Walks limited distances with or without assistance

FAMILY HISTORY

Please indicate if anyone in the family (parents/siblings/grandparents) has any of the following:

		Who is affected?/Diagnosis
Developmental Disorder (e.g., cognitive impairment, autism, speech delays, special education services, learning disability)	☐ Yes ☐ No	
Vision/Hearing Impairment	☐ Yes ☐ No	
Seizure Disorder	☐ Yes ☐ No	
Neurological Disorder	☐ Yes ☐ No	
Heart Disorders	☐ Yes ☐ No	
Psychiatric Disorders (ADHD/ADD, depression, bipolar disorder, schizophrenia, suicide, anxiety, obsessive-compulsive disorder, eating disorders)	☐ Yes ☐ No	

Other:

SCHOOL HISTORY

Is child in daycare? ☐ Yes ☐ No Name of Daycare: _____

Is your child homeschooled? ☐ Yes ☐ No What grade level of work is your child currently completing? _____

Is your child in school? ☐ Yes ☐ No If so, what grade in school? _____

Name of your child's School and School District (where your child attends or will attend): _____

_____

Does your child have an established IEP from School? ☐ Yes ☐ No **If yes, please attach a copy of the current IEP.**

SOCIAL HISTORY

Are your family's basic needs (food/shelter/safety) currently being met?

□ Yes □ No If no, please explain: _____

_____

Are there any significant stressors in the home (arguing/bullying/moves/separation/divorce/etc.)?

□ Yes □ No If yes, please explain: _____

_____

Is your child currently involved in any extracurricular activities?

□ Yes □ No If yes, please list: _____

_____

THERAPY HISTORY

Has your child ever received any of the following services? □ Yes □ No If yes, please check all that apply:

Therapy	Type	Where:
□ Physical Therapy	□ Individual □ Group □ Currently Receiving	
□ Occupational Therapy	□ Individual □ Group □ Currently Receiving	
□ Speech/Language Therapy	□ Individual □ Group □ Currently Receiving	
□ Social Work/Counseling	□ Individual □ Group □ Currently Receiving	
□ Developmental Therapy	□ Individual □ Group □ Currently Receiving	
□ Assistive Technology	□ Currently Receiving	
□ Nutrition	□ Currently Receiving	
□ Vision Therapy	□ Currently Receiving	
□ Feeding Therapy	□ Currently Receiving	
□ Audiology/Hearing Test	□ Currently Receiving	
□ ABA (Applied Behavioral Analysis)	□ Currently Receiving	
□ Other:		

ADDITIONAL INFORMATION

What is your family's preference in time/day for appointment?

Is there anything else we should know about your child or family?

Do you have a way to organize your child's medical records? □ Yes □ No

If not, would you like assistance or further information? □ Yes □ No

_____ _____

Client/Parent/Guardian/Surrogate Signature ***Date***

Thank you for the opportunity to serve your family!

Informed Consent for Services

Child's Name: _____ **DOB:** _____

I authorize the enrollment of the above named individual in the following services:

- ☐ ABA (Applied Behavioral Analysis)
- ☐ Assistive Technology/Orthotics/Splints
- ☐ Autism Dx Clinic/PLAY/ALC
- ☐ Counseling Services
- ☐ Developmental Screening
- ☐ Developmental Therapy
- ☐ Neurodevelopmental Evaluation
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech/Language/Feeding Therapy
- ☐ Other (specify): _____

By consenting to the services, I understand that:

1. My consent is voluntary and may be withdrawn at any time.
2. Individuals receiving services may be observed by persons interested in Easterseals programs.
3. Health information will be used for treatment.
4. Health information will be used for quality assurance activities.
5. Written reports shall not be released except to those professionals designated on consent for release of information.
6. The individual's confidential file will be maintained for a minimum of seven (7) years.
7. Information regarding above-named service(s) has been explained to me.

I have read the above information and fully understand the services to which I hereby consent. I release the agency and their trustees, officers, agents, and employees from any liability to the client for any personal injury or property damage suffered by the client as a result of participation in the services. I assume all responsibility and agree to indemnify the agency and hold the agency harmless from and against any and all liability or costs arising from or in connection with the client's participation in the services. In case of accident or sickness, I consent to emergency medical care provided by ambulance or hospital personnel.

_____ _____

Client/Parent/Guardian (PRINT) Date Client/Parent/Guardian (SIGNATURE) Date

---

☐ I authorize information regarding appointments/questions to be left on my answering machine/voicemail, email, and/or by text. Emails will also be used to share important Easterseals information including but not limited to, upcoming events, and advocacy efforts.

Cell Phone #1: _____ Carrier (for texting): _____

Cell Phone #2: _____ Carrier (for texting): _____

Email address: _____ Email address: _____

☐ I do not wish to provide my email or cell phone carrier.

☐ **I have received and reviewed a copy of the Easterseals Notice of Privacy Practices (HIPAA).**

☐ **I have received and reviewed a copy of the Easterseals Parent Handbook.**

_____ _____

Client/Parent/Guardian (PRINT) Date Client/Parent/Guardian (SIGNATURE) Date

_____

Received by Date

Consent for Release of Information

Child's Name: _____ **DOB:** _____

	School:	**Physician:**	**Specialist:**	**Other:**
	Address:	Address:	Address:	Address:
	Phone:	Phone:	Phone:	Phone:
	Email:	Email:	Email:	Email:

	Obtain	**Release**	**Obtain**	**Release**	**Obtain**	**Release**	**Obtain**	**Release**
All Communication and records								
Therapy: Reports/Progress Notes/Treatment Plans								
Audiological: Reports/Progress Notes/Treatment Plans								
Vision: Reports/Progress Notes/Treatment Plans								
Medical: Reports/Progress Notes/Treatment Plans								
Psychological/Psychiatric: Reports/Treatment Plans								
ASD Reports:								
IFSP/RCP/IEP								
Ongoing written and/or verbal communication								
Other:								

- This information is needed for the following purpose(s): To provide communication among service provider team.
- This consent for the disclosure is valid for: **One year from the date of signature.**
- I understand that I have the right to inspect and copy the information to be disclosed. I understand that I may withdraw the consent by the written request at any time. I understand that my refusal to consent to disclosure will have the following consequences, if any: Information will not be disclosed.
- I authorize Easterseals to release/obtain the following information to/from the following providers to be disclosed by verbal and/or written communication.

_____ _____

Client/Parent/Guardian (PRINT) Client/Parent/Guardian (SIGNATURE) Date

_____

Received by Date

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not re-disclose any information covered by these Acts unless the person who consented to the disclosure specifically consents to such re-disclosure. Under HIPAA regulations only minimum necessary information will be released/ obtained.

easterseals
taking on disability together

Financial Agreement

Child's Name: _____

Date of Birth: _____ ☐Male ☐Female Social Security #: _____

Mother's Name: _____ Father's Name: _____
Social Security #_____ Social Security # _____
Driver's License #_____ Driver's License # _____
Name of Person Responsible for payment: _____
Address: _____
City/State/Zip: _____
Home Phone #: _____ Work Phone #: _____

PRIMARY INSURANCE INFORMATION

Insured: _____ Employer: _____
Insured's SS#: _____ Employer Phone #: _____
Group Insurance #: _____ Policy #: _____
Insurance Company: _____
Street Address: _____
City/State/Zip: _____
Contact Name: _____ Insurance Phone #: _____

SECONDARY INSURANCE INFORMATION

Insured: _____ Employer: _____
Insured's SS#: _____ Employer Phone #: _____
Group Insurance #: _____ Policy #: _____
Insurance Company: _____
Street Address: _____
City/State/Zip: _____
Contact Name: _____ Insurance Phone #: _____

MEDICAID INFORMATION

Recipient #: _____

DSCC INFORMATION

ID#:_____ Case Manager: _____

(OVER)

Financial Agreement

Child's Name: _____

I understand the following statements and agree with them:

1. Easterseals Central Illinois will file all insurance claims when applicable. It is my responsibility to verify coverage with my insurance company. **I understand that a quote of benefits from my insurance company is not a guarantee of payment. I also understand that all copays and deductibles are due and should be paid at the time of service and payment of my child's medical bills is my responsibility and I am responsible for all charges denied by my insurance company.**

2. If I receive any insurance payments directly for Easterseals Central Illinois services, I will forward these to Easterseals Central Illinois, Client Financial Services, within seven (7) days of my receipt of the payment; otherwise I am responsible for the associated charges.

3. It is my responsibility to follow up on all requests for more information from the insurance company. If charges are denied due to my lack of response, the charges will become my sole responsibility.

4. I will notify Easterseals Central Illinois immediately of any change in my insurance or financial status in order to revise this financial agreement. Failure to notify Easterseals Central Illinois, Patient Accounts, of any changes will result in my being responsible for all charges that may occur. **I am responsible to present my new insurance card at check in on the first applicable visit.**

5. **Client families are expected to pay outstanding personal balances in full each month. Payments are due within 30 days unless other arrangements are made in advance with the client financial services department.**

6. If I have any questions regarding my financial agreement or understanding my financial obligation, I will contact Client Financial Services/Department at (309) 686–1177.

7. I authorize and assign payment of benefits to Easterseals Central Illinois.

8. I have read this agreement and agree to comply with it. If I do not comply with the terms of this agreement, Easterseals Central Illinois will have the right to terminate service(s).

_____ _____

Signature of Responsible Party Approved By

_____ _____

Date Date