



Rollercoaster Kids!

Rollercoaster Kids serves children ages **3 through 16** providing speech therapy, occupational therapy and social skills training.

Individual speech and occupational therapy services include:

- Speech therapy for a full spectrum of speech, language and communication disorders
- Feeding therapy for children with difficulties sucking, swallowing, chewing or tolerating foods
- Occupational therapy for difficulties with fine and gross motor skills, sensory processing and self care skills/activities of daily living

Friendship Groups are designed to help children learn to relate, communicate and think. *(Stanley Greenspan)*

Groups are formed for children ages 3 to 16 who have difficulties with self-regulation, sensory-regulation, over- or under-activity, attention, communication and relating to others. Additionally, participants may be socially disconnected, physically awkward, fixated on specific objects or interests, or have unusual speech or communication patterns. Addressing and improving skills in these areas allows children to interact more successfully with family and friends at home, school and in the community. No specific diagnosis is required, but some of the common ones we see include: Autism Spectrum Disorders (ASD), Communication Disorders and Sensory Processing/Integration Disorders (SPD). Information on these disorders is provided below.

Autism Spectrum Disorder (ASD) includes a wide range of disorders from mild to severe. Autism is characterized by a number of language delays or other similar communication problems, poor social skills, and rigid or otherwise unusual behavioral patterns. No longer considered a rare disorder, a child is diagnosed with an autism spectrum disorder every 20 minutes and it affects 1 in every 110 children.

Some signs and symptoms of ASD may include: development and then loss of language or social skills, fixation on single objects or topics, repetitive body movements such as hand flapping, spinning or rocking, difficulty tolerating change, over- or under-sensitivity to textures, lights or sounds, hyper- or hypo-activity, inability to interact with peers as expected, and/or difficulty making eye contact with others.

Communication Disorders are present in children who have deficits in their ability to exchange information with others. These disorders include speech and language delays characterized by slow or incomprehensible speech, pronounced difficulties in syntax (the order of words in a sentence) and articulation (the manner in which sounds are formed), as well as language disorders which are characterized by a child's decreased ability to understand and/or use words in context, both verbally and nonverbally. Children with communication disorders can be capable of high academic success if they learn the social, language and learning patterns needed in a classroom setting.

Some signs and symptoms of a communication disorder may include: difficulty following directions, attending to a conversation, pronouncing words, perceiving what was said, expressing oneself coherently, understanding questions or making oneself understood.

Sensory Processing/Integration Disorder (SPD) is a condition that exists when sensory signals *don't* get organized into appropriate responses. Because any interaction with our environment and other people requires us to take in, process and respond to sensory input, a disruption in the ability to process sensory signals may affect physical, social, emotional and/or cognitive development. SPD may be present along a continuum in which several or only one type of sensory processing is affected.

Some signs and symptoms of SPD may include: Hyper- or hypo-sensitivity to touch, movement, sound, smells, or oral or visual input, poor tactile perception and discrimination, poor muscle tone and/or coordination, sensory seeking behaviors (stomps, bumps, jumps), difficulty grading movement (uses too much or too little force, distance, speed), social, emotional, play and self-regulation dysfunction, walking on tiptoes, easily overwhelmed when over-stimulated, and/or auditory processing disorders.

Does your child show any of the above symptoms? **The Warren Center and Rollercoaster Kids** can help! Services include social skills (friendship) groups, summer day camp and individual speech and occupational therapies. A child may be referred to **Rollercoaster Kids** by anyone who suspects a child has differences in these areas. Physician prescription is required for services. Community grants allow for a limited number of sliding scale fee adjustments for those with demonstrated financial need.

Rollercoaster Kids is a program of **the warren center**, for children with developmental differences

Send us an email: RCK@thewarrencenter.org

320 Custer Road, Richardson, TX 75080 Phone: (972) 490-9055 Fax: (972) 490-9055 www.thewarrencenter.org

ROLLERCOASTER KIDS ENROLLMENT APPLICATION

a program of **the warren center**



We would like you to tell us about your child. The information that you provide will help us understand your child and your child's needs. This will allow us to work together for your child's best growth and development. If you have any questions, please contact us at 972-490-9055 or email us at RCK@thewarrencenter.org.

Person completing these forms _____ Today's Date _____

A completed application packet must include:

- ___ Enrollment Application
- ___ Authorization to Release Confidential Information
- ___ Emergency Authorization Form – MUST be **notarized** (can be notarized for free at our center)
- ___ Social Skills Profile – (separate document) – Please make additional copies as needed for teachers, caregivers, etc.
- ___ Parent Acknowledgement and Consent Form
- ___ Notice of Privacy Practices
- ___ Insurance Information Form
- ___ Therapy Evaluation Request – PHYSICIAN must complete this form. We can also fax it to the physician once we receive your enrollment packet if you prefer.
- ___ Copy of current immunization record - provide a copy or physician can fax to us at 972-490-9058
- ___ Copies of any evaluations by physicians, psychologists, therapists, schools, IEPs, behavior plans, etc.
- ___ Financial Resources (Page 1) **OPTIONAL *Required with documentation if requesting financial assistance**
- ___ Financial Resources (Page 2) **OPTIONAL *Required with documentation if requesting financial assistance**

Child's Information

Child's Name _____ Sex _____

Date of Birth _____ Ethnicity _____

Social Security # _____

Home address _____

City, State, Zip _____

Family Information

Mother's Name _____

Relation to child ___ Biological ___ Adoptive ___ Foster ___ Step-mother ___ Legal Guardian

Home address
(if different from child) _____

City, State, Zip _____

Home Phone _____ Cell Phone _____

Email address _____

Employer _____

Position _____ Work Phone _____

Work Address _____

Father's Name _____

Relation to child ___ Biological ___ Adoptive ___ Foster ___ Step-father ___ Legal Guardian

Home address
(if different from child) _____

City, State, Zip _____

Home Phone _____ Cell Phone _____

Email address _____

Employer _____

Position _____ Work Phone _____

Work Address _____

To be completed by Foster Parents (only)

Caseworker Name _____ Phone Number _____

Ad Litum Name _____ Phone Number _____

Marital status of parents:

_____ Married (Date _____) _____ Separated (Date _____)

_____ Divorced (Date _____) _____ Live together

Language(s) spoken at home: _____

Religious preferences or concerns: _____

Additional people who live in your home:

Name	Relation to child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other adults who share in your child's care (grandparents, aunts, uncles, friends):

Academic/Child Care Information

Does your child attend school/day care? Yes No

Name of School/Child Care: _____ City: _____ District: _____

Number of days per week: _____ Number of hours attended per day: _____

Does your child receive special services at school? ____ Please describe: _____

How is your child performing academically or pre-academically? _____

Please describe any problems your child has at school _____

Does your child have a Behavior Support Plan? _____ If so, please provide a copy.

Birth Information

Complications during pregnancy? (i.e. threat of miscarriage, illness, injury, etc.)

Full-term _____ Premature _____ Type of delivery _____ Birth weight _____

Complications during delivery? _____

Family History

Family changes during the past 5 years (include dates)

(i.e. moves, loss of job, death of family members or friends, divorce, illness, etc.)

Family history of birth defects, developmental problems, emotional difficulties:

Developmental History

Feeding: Has your child had any difficulties with feeding? What are your concerns?

Elimination: Has your child experienced difficulties with diarrhea or constipation?

Is your child toilet trained? *Circle one:*

Completely Most of the time Wets bed In Progress Not started

Sleeping: Give a brief description of sleep patterns.

(Include where your child sleeps, his usual schedule, and any problems or concerns.)

Milestones (estimate age if unsure):

Smiled at people _____ Pulled up _____

Crawled _____ Walked alone _____

Used words _____ Used short sentences _____

Asked questions _____ Played with others _____

Wrote own name _____ Made a friend _____

How does your child interact with others (peers, siblings, parents)?

Does your child experience difficulty with any of the following? *(please circle Y or N)*

<input type="checkbox"/> Y	<input type="checkbox"/> N	Following directions	<input type="checkbox"/> Y	<input type="checkbox"/> N	Using words to communicate
<input type="checkbox"/> Y	<input type="checkbox"/> N	Answering questions	<input type="checkbox"/> Y	<input type="checkbox"/> N	Establishing friendships
<input type="checkbox"/> Y	<input type="checkbox"/> N	Asking questions	<input type="checkbox"/> Y	<input type="checkbox"/> N	Maintaining attention/focus
<input type="checkbox"/> Y	<input type="checkbox"/> N	Pronouncing words or sounds	<input type="checkbox"/> Y	<input type="checkbox"/> N	Loud noises
<input type="checkbox"/> Y	<input type="checkbox"/> N	Running, jumping, climbing	<input type="checkbox"/> Y	<input type="checkbox"/> N	Bright lights
<input type="checkbox"/> Y	<input type="checkbox"/> N	Cutting, tying shoes, buttoning	<input type="checkbox"/> Y	<input type="checkbox"/> N	Attending to tasks
<input type="checkbox"/> Y	<input type="checkbox"/> N	Grooming <i>(i.e. bathing, brushing teeth, hair, washing hands, toileting)</i>	<input type="checkbox"/> Y	<input type="checkbox"/> N	Obsession with or avoidance of swinging, spinning, and/or bouncing
<input type="checkbox"/> Y	<input type="checkbox"/> N	Dressing themselves, putting on clothing	<input type="checkbox"/> Y	<input type="checkbox"/> N	Playing in dirt, sand and/or grass
<input type="checkbox"/> Y	<input type="checkbox"/> N	Tolerating clothing	<input type="checkbox"/> Y	<input type="checkbox"/> N	Playing on the playground
<input type="checkbox"/> Y	<input type="checkbox"/> N	Different textures (touching or during feeding)	<input type="checkbox"/> Y	<input type="checkbox"/> N	Coloring, writing, drawing

Check any attributes that describe your child's typical daily behaviors:

- | | | |
|--|--|--|
| <input type="checkbox"/> Mostly quiet | <input type="checkbox"/> Restless | <input type="checkbox"/> Cries often |
| <input type="checkbox"/> Tires easily | <input type="checkbox"/> Poor attention span | <input type="checkbox"/> Easily frustrated |
| <input type="checkbox"/> Too impulsive | <input type="checkbox"/> Overly active | <input type="checkbox"/> Fights frequently |
| <input type="checkbox"/> Stubborn | <input type="checkbox"/> Talks constantly | <input type="checkbox"/> Rocks self frequently |
| <input type="checkbox"/> Overreacts | <input type="checkbox"/> Has nervous habits or tics | <input type="checkbox"/> Clumsy/falls often |
| <input type="checkbox"/> Usually happy | <input type="checkbox"/> Resistant to changes | <input type="checkbox"/> Has difficulty learning new tasks |
| <input type="checkbox"/> Has difficulty separating from primary caregivers | <input type="checkbox"/> Exhibits frequent temper tantrums | |

Related Medical Information

List any allergies (*food, drug, bug bite, etc.*): _____

Emergency medication or Epipen? Yes No If yes, please explain: _____

*** the warren center staff will not administer medication at our center.**

Are there any medical precautions the therapist should be aware of when working with your child? (i.e. seizures) Yes No If yes, please explain: _____

Menstruating? Yes No N/A

Does your child have a specific diagnosis? _____

Has your child had a vision test? Yes No If yes, when and by whom? _____

Results: _____

Has your child had a hearing test? Yes No If yes, when and by whom? _____

Results: _____

Please list current/past **DOCTORS** who have seen your child for this condition: (*attach pages if needed*)

Your child's primary care physician information is REQUIRED – please list it FIRST.

Name	Phone	Fax	Specialty	Dates
------	-------	-----	-----------	-------

Please list current/past **THERAPISTS** who have worked with your child: (*attach pages if needed*)

Name	Phone	Fax	Specialty	Dates
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Please list current/past **EVALUATIONS** your child has had: (therapies, school district evaluations including ARD Reports, IEPs and behavior support plans, psychological testing, developmental testing, etc.) **Please provide us with copies of all evaluations.**

Date	Name of Provider	Phone	Fax	Reason

Hospitalizations/surgeries - list each separately (attach pages if needed)

Date _____ Age _____ Length of stay _____ Procedure/Reason _____

Date _____ Age _____ Length of stay _____ Procedure/Reason _____

Personal Characteristics

Describe any characteristics that will help us better know your child as an individual - likes and dislikes; favorite toys & foods; favorite games and activities; what you like best about your child; what concerns you most about your child, etc.: **(attach pages if needed)**

Time Availability *Evaluations generally require time away from school. Notes for excused absences will be provided upon request.

Does your child attend school during the day? Yes No

If so, what are the days and hours he/she is at school? _____

For after school appointments, what is the earliest time you can have your child here? _____

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

PLEASE PRINT

Please fill in the names of physicians, therapists, schools, etc with whom you would like for us to coordinate care for your child. We must communicate with a primary care physician in order to secure authorization of treatment.

Child's Name _____ Date of Birth _____

I hereby consent to and authorize the persons/agencies/groups listed below to disclose information and release records regarding treatment, medical, educational and/or behavioral health conditions of the child named above, as well as to exchange information regarding the condition and ongoing care of said child with:

the warren center, *for children with developmental differences*

320 Custer Road, Richardson, TX 75080

Phone (972) 490-9055 FAX (972) 490-9058

PRIMARY CARE PHYSICIAN-REQUIRED Phone (_____) _____ FAX (_____) _____

Provider/Agency/Group Name Phone (_____) _____ FAX (_____) _____

Provider/Agency/Group Name Phone (_____) _____ FAX (_____) _____

Information to be released/exchanged includes:

- | | |
|---|--|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> ARD Records |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Individual Educational Plan (IEP) |
| <input type="checkbox"/> Medication Records | <input type="checkbox"/> Behavioral Support Plan |
| <input type="checkbox"/> Treatment Plan and Records | <input type="checkbox"/> Ongoing periodic contacts |
| <input type="checkbox"/> Behavioral Health Treatment Plan & Records | <input type="checkbox"/> Admission Summaries |
| <input type="checkbox"/> Evaluations/Assessments | <input type="checkbox"/> Discharge Summaries |

The authorized purpose(s) for this release are:

- | | |
|---|--|
| <input type="checkbox"/> Diagnosis and Treatment | <input type="checkbox"/> Transitioning to other services |
| <input type="checkbox"/> Coordination of Care | <input type="checkbox"/> Third Party Payment Purposes |
| <input type="checkbox"/> Determining appropriate services | <input type="checkbox"/> Other (specify) _____ |

Initial ____ I understand that my/my child's health, behavioral health and educational records are protected from disclosure under federal and/or state law. I may revoke this authorization. This authorization is valid until I revoke it or until 12 months after I have completed treatment, whichever is sooner. Once I revoke this authorization, no information can be released except as authorized or allowed by law. File copy is considered equivalent to the original.

Initial if applicable ____ **NOTICE OF REFUSAL TO RELEASE INFORMATION:** I have reviewed the above release of information form and refuse to authorize release of health, behavioral health and educational records/information to the warren center, inc.

I signed this authorization voluntarily on (date): ____/____/____.

Signature of Parent/Guardian

Relationship to Child

Signature of Witness

You have the right to ask us about this form. You have the right to review the information you give us on the form (some exceptions). If the information is wrong, you can ask us to correct it. To discuss the form or ask for corrections contact the warren center (contact information above).

ROLLERCOASTER KIDS AND WARREN CENTER EMERGENCY AUTHORIZATION FORM



Child's Name: _____ **Birth date:** _____

Address: _____

This form must **be completed and notarized** prior to attendance in center-based programs.

List phone numbers to contact in an emergency in order to call

Mother's Name: _____

1 _____ Please circle: Cell Work Home Other

2 _____ Please circle: Cell Work Home Other

Father's Name: _____

1 _____ Please circle: Cell Work Home Other

2 _____ Please circle: Cell Work Home Other

Other Emergency Contact: _____ Relation to child: _____

1 _____ Please circle: Cell Work Home Other

Child's physician: _____ Phone number: _____ Hospital _____

- In the event of an accident or illness, the warren center will attempt to contact parents first and then your emergency contact. If parents and the emergency contact are unavailable, then we will call 911.
- I, the undersigned, do hereby authorize the staff of the warren center to contact directly the persons named on this form, and authorize the named physician to render such treatment as may be deemed necessary in an emergency for the health of said child.
- In the event the physician, other persons named on this form, or parents cannot be contacted, the warren center is hereby authorized to take whatever action is deemed necessary in their judgment for the health of the aforesaid child.
- I will not hold the warren center financially and/or legally responsible for the emergency care and/or transportation of said child.
- I understand the necessity for accurate information on my child in case of an emergency and agree to inform the warren center of any changes. Furthermore, I have read the medical emergency policies of the warren center and understand the procedures to be followed.
- I hereby release, relinquish and forever discharge the warren center and the warren center's staff, their successors or assigns, from any and all claims, demands, causes of action, liability, damages or other rights which I may have or hereafter have arising from, growing out of or on account of any loss, damage or expense in connection with the emergency medical treatment of my child while in the care of the warren center.

My signature below indicates that I have read, understood, authorized and consented to the above statement.

Signature of Parent or Guardian

State of Texas

County of _____

Before me, the undersigned authority, on this date personally appeared _____, knowing to me to be the person whose name is subscribed above, and acknowledge to me that he/she executed the same for the purpose therein expressed.

Sworn and subscribed before me this _____ day of _____, 20_____

Notary Public in and for

County, Texas

Parent Acknowledgement and Consent Form

Child's Name: _____ **Date of birth:** _____

Initial _____ Consent to Treat: I hereby consent and authorize the warren center, inc., its agents and associates to evaluate and provide care to my child per program policy and/or as prescribed by physician.

Initial _____ Photography/Video Release: I give my permission for my child to be photographed and videotaped while participating in activities at the warren center, inc., and agree that images may be used for assessment, education, publicity, and to be given to other participants in group activities.

Initial _____ Students and Interns: I understand that the warren center, inc. is a clinical teaching facility and give my permission for student interns to observe and/or assist with care under the direct supervision of a fully qualified professional.

Initial _____ Attendance and Fee Policies: I have read, understand and agree to abide by the attendance and fee policies described below:

- All appointments are scheduled at specific times. Clients who arrive late will not have their appointment time extended and remain responsible for the full therapy rate.
- In order to prevent disruptions in therapy, group participants arriving more than 15 minutes late to a scheduled group therapy session will not be allowed to enter the session and will be charged a missed visit fee.
- I understand that if I do not cancel an appointment more than 24 hours in advance, I will be charged a missed visit fee.
- I understand that if my child misses an appointment, the charge is for a full fee. Charges for missed visits are not covered by insurance, Medicaid or scholarship funds and are therefore my responsibility.
- I understand that fees are payable at the time services are rendered or as invoiced.
- I understand that enrollment in this program is voluntary and I may withdraw my child at anytime. Fees for provided services are due even if I withdraw my child.
- I understand that my child's records will be kept confidential and will not be released without my written consent, and that I may have a copy of my child's records upon request.
- I understand that my child's records will be retained for five years after dismissal from Rollercoaster Kids.

Initial _____ I affirm that I am the parent/legal guardian of the above referenced child and in that capacity I am able to make healthcare-related decisions for the child.

I hereby release, relinquish and forever discharge **the warren center** and the warren center's staff, their successors or assigns, from any and all claims, demands, causes of action, liability, damages or other rights which I may have or hereafter have arising from, growing out of or on account of any loss, damage or expense in connection with the services and therapy provided my child by the warren center.

My signature below indicates that I have read, understood, authorized and consented to the above statements.

Parent/Guardian Printed Name

Relationship to Child

Signature of Parent/Guardian

Today's Date

Signature of Witness

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you/your child as a client of the warren center may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please review this notice carefully.

Our commitment to your privacy

the warren center, inc. is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We are also required by law to provide you with this notice of our legal duties and the privacy we maintain in our practice concerning your health information. We realize these laws are complicated, but we must provide the following important information to you. We also reserve the right to amend or revise this Notice of Privacy Practices as necessary.

Your rights regarding your/your child's health information

The health and billing records we maintain are the physical property of **the warren center, inc.** However, the information in these records belongs to you. You have the right to:

1. Request a restriction on certain disclosures and uses of your health information in writing to our office. We are not required to grant the request but we will comply with any request granted;
2. Request that you be allowed to inspect and copy your health record and billing record – you may exercise this request by delivering the request in writing to the office;
3. Appeal a denial of access to your protected health information except in certain circumstances;
4. Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
5. File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
6. Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
7. Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and
8. Revoke authorizations that you made previously to use or disclose information (except to the extent information or action has already been taken) by delivering a written revocation to our office.

If you would like to exercise any of the above rights, please contact **the warren center, inc.** in person or in writing. We will assist you in the steps you must take to exercise your rights.

Use and disclosure of health information in certain special circumstances

The following circumstances may require us to use or disclose your/your child's health information:

1. To public health authorities that are authorized by law to collect information
2. To health oversight agencies for activities authorized by law. These may include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions: civil administrative and criminal procedures or actions, or other monitoring programs of the government.
3. Lawsuits and similar proceedings in response to a court or administrative order;
4. If required to do so by a law enforcement official;
5. When necessary to reduce or prevent a serious threat to your/your child's health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat;
6. To the appropriate authorities, upon their request, if you are a member or veteran of US or foreign military forces
7. To federal officials for intelligence and national security activities authorized by law;
8. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official; and
9. For Workers' Compensation and similar programs.

Other disclosures and uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your/your child's care, about your location, general condition or death.

Communication with family

Using our reasonable discretion, we may disclose to your family member, other relative, close personal friend, or any other person you identify, or to a person who accompanies you/your child to therapy, health information relevant to that person's involvement in your/your child's care or in payment for such care if you do not object, or in an emergency.

Right to a copy of this notice

You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time.

Right to file a complaint

If you believe your privacy rights have been violated, you may file a complaint with **the warren center, inc.** or with the Secretary of the Department of Health and Human Services.

If you have any questions regarding this Notice of Privacy Practices, please contact:

the warren center, inc.
320 Custer Road
Richardson, TX 75080
Phone: 972-490-9055
Fax: 972-490-9058

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices for **the warren center, inc.**

Printed Name of Patient

Parent/Guardian Printed Name

Relationship To Child

Parent/Guardian Signature

Date

Please return this signed form to: **the warren center, inc.**
320 Custer Road
Richardson, TX 75080
Phone: 972-490-9055
Fax: 972-490-9058

INSURANCE INFORMATION – PLEASE PRINT

Patient/Child Information:

Last Name	First	Middle	Birth date	Sex	SS#
Address			City	State	Zip code
Father		Home Phone	Work Phone		Cell Phone
Mother		Home Phone	Work Phone		Cell Phone
Primary Physician (physician prescribing treatment)				Physician's Phone	

Primary Insurance Company			Policy Holder Name		
Policy Holder Employer			SS#	Birth date	
Policy Holder Address (if different from patient)			City	State	Zip code
Group #			ID or Policy #		
Claims Address:					Phone

Secondary Insurance Company			Policy Holder Name		
Policy Holder Employer			SS#	Birth date	
Group #			ID or Policy #		
Claims Address:					Phone

ASSIGNMENT OF INSURANCE/LIABILITY BENEFITS: I hereby authorize and request payment of authorized benefits be made on my behalf directly to **the warren center, inc.** and all providers involved in my/my child's treatment or diagnosis at **the warren center** by the group insurance, major medical insurance, Medicaid or other public health insurance, hospital, surgical, medical, and any other insurance payable to or on behalf of the above named patient or the undersigned, by virtue of services provided to the above named patient. I unconditionally assign any insurance benefits to **the warren center** and all providers involved in my/my child's treatment and further authorize and request both to apply any surplus benefits or any other payments received from any source, to the payment of other unpaid bills of the above named patient or of the undersigned or any individual who is financially responsible for the patient or guarantor. I understand that I am financially responsible to **the warren center** and all providers for charges not paid by insurance. If an unpaid balance is sent to a collection agency, I will be responsible for any legal fees and/or interest associated with collection of debt.

My signature below indicates that I have read, understood, authorized and consented to the above statements.

I signed this authorization voluntarily on (date): _____/_____/_____.

Signature of Parent/Guardian Relationship to Child Signature of Witness

ROLLERCOASTER KIDS THERAPY SERVICES

THERAPY EVALUATION REQUEST

PHYSICIAN must complete this form. Parent can request physician to complete it, or we can fax the form to the physician for you, if you prefer.



Fax to Doctor: _____

Fax Number: _____

of pages (including cover): _____

Child's Name: _____

Date of Birth: _____

Request for assessment for participation in therapy services through the Rollercoaster Kids program at **the warren center**, for children with developmental differences has been made for the child named above. Your comments and medical information are vital in evaluating, planning and implementing an appropriate therapy and intervention program, so we require a signed physician's prescription prior to evaluation and treatment. Please fill out the form below completely, sign and date. A copy of the evaluation, plan of care and periodic updates will be submitted to you for approval.

Evaluations for the following services have been requested for the child above:

(check all areas for which evaluation is being requested):

- ___ Social Skills Group Therapy (consisting of occupational & speech therapies)
- ___ Speech Therapy
- ___ Occupational Therapy
- ___ Feeding Therapy

Primary Diagnosis (required): _____ **ICD-9 Code (required):** _____

Other Diagnosis: _____ ICD-9 Code (required): _____

Other Diagnosis: _____ ICD-9 Code (required): _____

*Precautions: _____

PHYSICIAN SIGNATURE _____ **Date** _____

(Required)

(Required)

Printed Name _____ **License #** _____

(Required)

(Required)

My signature above certifies/recertifies that this patient is under my care and I have authorized evaluation for the services listed and will periodically review the plan of care. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal or State funds may be subject to fine, imprisonment, or civil penalty under applicable Federal and State laws.

RETURN BY FAX TO: 972-490-9058

THANK YOU!

I prefer that contact regarding this patient occur:

___ By FAX () _____ Attention: _____

___ By phone () _____ Contact Person: _____

___ By email _____

___ By mail to address: _____

Rollercoaster Kids is a program of **the warren center**, for children with developmental differences
320 Custer Road, Richardson, TX 75080 Phone: (972) 490-9055 Fax: (972) 490-9058 Email: RCK@thewarrencenter.org
www.thewarrencenter.org

*The information contained in this fax message may be privileged and confidential information and is intended only for the use of the individual and/or entity identified above. If the reader of this message is not the intended recipient, or an employee or agent responsible to deliver it to the intended recipient, you are hereby requested not to distribute or copy this communication. If you have received this communication in error, please notify us immediately by telephone or return fax (numbers above) and destroy the original document.

**These two pages are OPTIONAL. Only fill them out if you are requesting financial assistance.
Limited funds are available for those with demonstrated financial need.**

REQUEST FOR FINANCIAL ASSISTANCE

(Page 1 of 2)

**Please contact Caroline Hazlett, Rollercoaster Kids Program Director, with questions:
972-490-9055 or RCK@thewarrencenter.org**

Child's Name _____ Date of birth _____ Today's date _____

REQUEST FOR ADJUSTMENT IN GROSS ANNUAL INCOME

I am requesting adjustment in our gross annual income based on the following factors:

Documentation of expenses is required for an adjustment in income.

Family size: _____ **Number of other children enrolled in The Warren Center** _____

Gross Annual Income - Please provide **documentation** of W2 forms, tax return or pay stubs from the last 2 months.

\$ _____

1. Allowable Expense:

Outstanding medical and dental expenses for family, expected to be paid during the term of enrollment at the warren center – this may include medical/dental debt to be paid (Provide copies of bills, statements, EOB, receipts, etc.)

- \$ _____

2. Allowable Expense:

Annual insurance premiums and other expected medical expenses to be incurred during the upcoming year (Provide copies of paycheck stub or insurance enrollment form if premium amount is included)

- \$ _____

3. Allowable Expense:

Childcare expenses up to \$500 per month (Provide cancelled check, receipts, or tuition statement)

- \$ _____

4. Allowable Expense:

Child support for children not counted in family size figure (Provide cancelled checks from past 3 months or court order)

- \$ _____

5. Allowable Expense:

Adoption expense up to \$5000 (Provide adoption contract and cancelled checks or receipts)

- \$ _____

Subtotal \$ _____

6. Other Requested Allowable Expense:

Other requested: Explain on next page and provide documentation

- \$ _____

Adjusted Gross Income \$ _____

Office use	Verified	Date
Y N		
Y N		
Y N		
Y N		
Y N		
Y N		
Y N		
Y N		
Y N		

***These two pages are OPTIONAL. Only fill them out if you are requesting financial assistance.
Limited funds are available for those with demonstrated financial need.***

REQUEST FOR FINANCIAL ASSISTANCE

(Page 2 of 2)

***Please contact Caroline Hazlett, Rollercoaster Kids Program Director, with questions:
972-490-9055 or RCK@thewarrencenter.org***

Child's Name _____ Date of birth _____ Today's date _____

OTHER REQUESTED ALLOWABLE EXPENSES

I am requesting further adjustment in our gross annual income based on the following factors:
Please provide documentation for any ***financial circumstances*** listed below.

Change in family circumstances: (explain)

Catastrophic loss: (explain)

Other extraordinary/unusual circumstances: (explain)

Parent/Guardian Printed Name

Relationship to child

Parent/Guardian Signature

Date