Therapy Description

At **Ability Plus Therapy**, our team of licensed and certified therapists evaluate each child at the beginning and end of the three-week therapy session. Through collaboration with the parents and the child we design an appropriate goal oriented therapy program. The child participates in the chosen program 5 days a week, for a three-week period totaling 45 - 60 hours of intensive therapy. Each treatment day begins with a preparation phase utilizing hot packs and/or massage, followed by a program specifically designed to meet your child's needs. The therapy program will include a combination of activities utilizing the TheraSuit™ and the Universal Exercise Unit, as well as joint mobilization, elongation of shortened muscles, strengthening exercises, functional skills, sensory integration, vestibular and gait training. The rigorous therapy program and use of the TheraSuit™ help to "re-train" the child's brain to understand and eventually duplicate the signals from the proper muscle movement.

What is TheraSuit™?

TheraSuit™ is a breathable, soft dynamic, form-fitting, orthotic comprised of a cap, vest, shorts, kneepads, and specially adapted shoes that are connected with each other through a system of adjustable straps and elastic bands which are designed to put the body in proper alignment. It was designed by Izabela and Richard Koscielny in 2002 (U.S. patent pending). The Koscielny's are pediatric physical therapists, who are also parents of a child with cerebral palsy.

How does TheraSuit™ work? (from www.suittherapy.com)

TheraSuit™, thanks to its construction and improvements, creates a breathable soft dynamic orthotic. Its major goal is to improve and change proprioception (*the ability to sense the position, location, orientation and movement of the body*), reduce patient's pathological reflexes, restore physiological muscle synergies (*proper patterns of movement*) and load the entire body with weight (*process similar to a reaction of our muscles to gravitational forces acting up on us for 24 hours*). All of the above normalizes different vestibular proprioceptive input (*information arriving to vestibular system*). The vestibular system is a tremendously important center. It processes, integrates and sends back all the information that arrives from muscles, joints, tendons, etc. It influences muscle tone, balance and position of the body in space. The more correct proprioception, from the joints, ligaments, muscles, tendons, and joint's capsule, the more correct alignment results. The vicious circle can be interrupted and the incorrect information replaced by a "new" correct one.

A patient (child) diagnosed with Cerebral Palsy and other neuro-motor disorder requires hundreds of repetitions of any particular (unknown or incorrect) movement. We believe that as individuals, we all have a "magic" number. For example: a baby that is trying to push-off the floor will need to repeat this movement a few hundred times in order to master it. Another child may need either more or less repetitions to learn the same skill. For the child with cerebral palsy, however, this fairly low "magic" number grows to thousands of repetitions to learn and master new skills. TheraSuit™, worn over prolonged time, will correct proprioception and accelerate the progress. Thanks to the TheraSuit™ and physical movement (therapy), the skills practiced will become more fluent and require less and less effort. Therefore, TheraSuit™ facilitates development of new gross and fine motor skills like sitting, standing, walking.

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What are the benefits of Suit Therapy?

1) Re-trains the central nervous system
2) Promotes regulation of abnormal muscle tone
3) Promotes regulation of pathological reflexes
4) Improves body alignment and movement patterns
5) Improves gait pattern
6) Provides tactile and deep pressure stimulation
7) Decreases uncontrolled movements in ataxia and athetosis
8) Influences the vestibular system promoting body and spatial awareness
9) Improves balance
10) Improves coordination
11) Provides resistance for strengthening
12) Improves speech production and its fluency through head control and trunk support
13) Promotes development of fine and gross motor skills
14) Improves bone density

Who benefits from Suit Therapy?

Patients with following the indications:

1) Autism Spectrum Disorders
2) Cerebral Palsy
3) Developmental Delays
4) Traumatic Brain Injury
5) Post stroke (CVA)
6) Genetic Disorders
7) Down Syndrome
8) Ataxia
9) Athetosis
10) Hypertonia
11) Hypotonia

Contraindications:

1) Hip subluxation greater than 50%
2) Severe scoliosis

Precautions:

1) Heart conditions
2) Uncontrolled seizure activities
3) Hip subluxation
4) Hydrocephalus (VP shunts)
5) Diabetes
6) Kidney problems
7) High blood pressure

What is the Universal Exercise Unit?

The Universal Exercise Unit (UEU) is a system of pulleys, straps, weights, splints, belts and bungies utilized to perform variety of exercises.

What are the benefits of the Universal Exercise Unit?

1) Improves strength, range of motion and flexibility
2) Isolates desired (weakened) muscle and muscle groups
3) Promotes vestibular input
4) Improves balance, coordination and sensory integration
5) Promotes functional skill development, independence and self confidence
6) Promotes partial or full weight bearing
7) Promotes motor learning and motor planning

Date:_____________

NEW PATIENT INFORMATION FOR INTENSIVE THERAPY

Child's Name: ____ Sex: ☐ M ☐ F Date of

Age: ______________ Height: ___________ Weight: ___________ Social Security #: ________

Parents/Guardian Names: ____

Child lives with: ☐ Birth Parents ☐ Adoptive Parents ☐ Foster Parents ☐ Other: _____________________________

Home Address: ____

Home Phone: ________________________________ Email: ____

Work Phone: Mom:_____________________________________ Dad: ____

Cell Phone: Mom:_____________________________________ Dad: ____

Names of siblings and ages: ____

Name of School: ____ Grade: _______ Main streamed? _______

Services currently received at school and privately (specify): ____

____

Equipment used at home (i.e. walker, braces, etc. - Month, year purchased):______________________________________

____

Equipment used at school: ____

Any difficulties with home, school and community access: ____

____

Primary Care Physician: ____Phone: ______________________________

Specialists:____

Insurance: ☐ FL Medipass ☐ FL Medicaid HMO ☐ PPO ☐ Other HMO ☐ Trust ☐ Private Pay ☐ Other: ____________

What is your reason/concern for having your child participate in the intensive program? ___________________________

____

What function(s) would you like your child to be doing in the next 3 weeks (be specific)? __________________________

____

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MEDICAL HISTORY

Diagnosis: 1.____________________________2.____________________________3.________________________________

Date(s) of Onset: 1.______________________2.____________________________3.______________________________

Has your child had any of the following? ☐Adenoidectomy ☐Tonsillectomy ☐Tonsillitis ☐Measles ☐Mumps

☐Chickenpox ☐Shingles ☐Meningitis ☐Encephalitis ☐ Cytomegalovirus ☐HIV/AIDS ☐ Hydrocephalus - shunt

☐Asthma ☐Ear tubes: when________ ☐Cochlear implant ☐Hearing aids ☐Eye glasses for ________________

Check any of the following problems your child has suffered from and explain:

	Yes	No	Comments
Seizures? Type and How often? Controlled by medication?			
Latex Allergy? Describe.			
Food Allergies? Describe.			
Other Allergies? Describe			
Colds/flus frequently? How often and how quickly he/she recovers?			
Other respiratory problems? Describe.			
Ear infections; when? Date of last hearing screening?			
Vision problems? Describe. Surgery and date? Date of last screening?			
Reflux? Controlled by medication?			
Other digestive problems? i.e. diarrhea/constipation. Describe.			
Aspiration of foods/liquids? Describe			
Drooling? Controlled by medication?			
Heart problems? Describe.			
Muscle spasms, cramps, tendinitis? Describe.			
Numbness, tingling, nerve damage? Describe			
Scoliosis? Degrees? Last x-ray? Correction surgery and date?			
Hip subluxation? Degrees? Last x-ray? Correction surgery and date?			
Other bone/joint problems? Describe.			

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Describe other surgeries or procedures he/she has had (myofascial release, Botox, lobectomy, dorsal rhizotomy, etc) :

____

____

____

List current medications, supplements and dosages: ____

____

____

List other treatments and therapies your child has had and/or is currently receiving and where: ____________________

____

____

BIRTH HISTORY

Weeks gestation: ________ Birth Weight: __________ Length: ____________

Delivery: ☐Vaginal (normal) ☐Forceps ☐Vacuum extraction ☐C-section

Complications during pregnancy? ☐ Yes ☐No Describe ____

____

Complications during delivery? ☐ Yes ☐No Describe ____

____

Complications after birth? ☐ Yes ☐No Describe ____

____

____

FEEDING HISTORY/CURRENT DIET

Breast fed: ☐Yes ☐No How long? _______ Formula fed: ☐Yes ☐No How long? _______ Type: _____________

Introduced to solids at _________________(age) Cow's milk at _______________ (age) Has G-tube: ☐ Yes ☐No

Had a barium swallow study? ☐Yes ☐No Date _____________ Chokes on foods/liquids? ☐Yes ☐No

Any eating/drinking restrictions? ☐ Yes ☐No Describe ____

____

Any food/texture intolerance? ☐ Yes ☐ No Describe ____

____

Describe child's current diet: ____

____

DEVELOPMENTAL HISTORY

List the approximate age your child first did the following (if applicable): Roll ___________ Sit alone __________

Crawl __________ Stand alone __________ Walk alone ___________ Babble __________

Say first words ___________ Put two words together _____________ Speak in short sentences ___________

Drink from sippy cup ___________ Drink from straw__________ Drink from regular cup ___________

Self-feed _________ Toilet train _________ Self-bathe ________ Brush teeth _________ Self-dress __________

Button pants/shirt _________ Zip/unzip pants __________ Tie shoes ________

CURRENT FUNCTIONS/ISSUES

Mark all that currently apply to your child:

GROSS MOTOR SKILLS:

☐ Holds head up (specify, how long?)____
☐ Pushes on elbows / extended arms (circle all that apply)
☐ Gets on all-fours (specify how) ____
☐ Crawls (specify how) ____
☐ Sits supported / alone (circle one, specify how and length) ______________________________
☐ Stands up from the floor (Specify how) ____
☐ Stands (Specify how and length) ____
☐ Walks (distance and equipment used, if any) ____
☐ Walks up/down stairs (specify how, support needed) __________________________________
☐ Can carry objects while walking (specify) ____
☐ Jumping
☐ Can keep up with peers
☐ Protects self using hands when he/she falls

FINE MOTOR & SELF-HELP SKILLS:

☐ Hold own bottle, cup
☐ Has difficulty managing personal hygiene
☐ Has difficulty dressing
☐ Has difficulty self-feeding
☐ Crosses midline to reach for object on the other side of the body
☐ Writes legibly

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ORAL MOTOR/FEEDING:

- ☐ Has difficulty chewing
- ☐ Has difficulty moving food with tongue to the sides
- ☐ Puts toys/objects in the mouth

COMMUNICATION & COGNITIVE SKILLS:

☐ Communicates: ☐ Verbal ☐ Word approximations ☐ Sign language ☐ Gestures ☐ Communication cards ☐ Device

- ☐ Makes sounds or says words that are difficult to understand
- ☐ Understands what you are saying
- ☐ Responds when name is called
- ☐ Follows simple directions
- ☐ Responds correctly to yes/no questions
- ☐ Repeats sounds, words or phrases over and over
- ☐ Recognizes objects, people, places
- ☐ Responds correctly to who/what/where/when/why questions
- ☐ Says sentences longer than 4 words under one breath
- ☐ Retrieves/points to familiar objects upon request
- ☐ Takes some time to respond or act upon request (delayed response)
- ☐ Stutters
- ☐ Demonstrates appropriate facial expressions (sad, happy, angry, tired, bored)
- ☐ Responds appropriately to facial expressions of others
- ☐ Has imaginative play
- ☐ Has difficulty matching or sorting
- ☐ Plays with toys for their intended purpose
- ☐ Easily remembers past events
- ☐ Has difficulty retaining previously taught concepts
- ☐ Has difficulty problem solving relative to age

SENSORY PROCESSING/REGULATION:

- ☐ Stumbles or falls frequently
- ☐ Appears awkward or less coordinated
- ☐ Demonstrates stiff or rigid movement patterns
- ☐ Has difficulty figuring out how to move body or takes more time to learn/perform motor tasks
- ☐ Has poor sense of body in space, runs into things
- ☐ Seeks external support for posture (leans on furniture, wall or people, slouches, holds head)
- ☐ Fatigues quickly
- ☐ Has difficulty visually attending to an object/person
- ☐ Gets easily distracted
- ☐ Calms self easily
- ☐ Gets angry/frustrated easily
- ☐ Gets destructive / aggressive toward others
- ☐ Has self-abusive behaviors
- ☐ Resists to novice tasks and environments
- ☐ Resists certain positions or movements (i.e. upside down, bouncing, swinging)
- ☐ Spins things or self
- ☐ Has sensitivity to light, sounds/noise
- ☐ Initiates hugs/kisses
- ☐ Does not tolerate certain textures (clothing, surfaces, foods, toys)(circle all that apply)
- ☐ Resists touch
- ☐ Avoids getting messy
- ☐ Seeks out (craves) touch or movement
- ☐ Seeks out (craves) visually stimulating objects
- ☐ Seeks out (craves) stimulating sounds
- ☐ Allows brushing of teeth
- ☐ Bangs on surface, bangs/hits head or uses a lot of pressure when touching someone or holding object
- ☐ Flaps hands
- ☐ Has difficulty finding objects with competing background (items on a desk, in a room, etc)
- ☐ Obsesses with a certain order of things
- ☐ Has difficulty transitioning from one activity to another (resists change)
- ☐ Has difficulty falling asleep
- ☐ Has difficulty remaining asleep through the night
- ☐ Appears lethargic / sleepy all the time
- ☐ Sleeps a lot

SOCIAL-EMOTIONAL SKILLS:

- ☐ Has difficulty making friends
- ☐ Plays with other kids
- ☐ Only plays with adults
- ☐ Prefers to play alone
- ☐ Has separation difficulties
- ☐ Gets easily frustrated/impulsive
- ☐ Has poor eye contact

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What activities, toys, games, TV shows, music is your child interested in? ____

____

____

What extracurricular activities is your child involved in (dance, sports)? ____

____

Do you currently have a home program that was given by a therapist in the past or that you self-taught to help your child? If so, describe what you do (i.e. stretching, strengthening activities, brushing, etc): ___________________________

____

____

____

____

List any adaptive equipment that your child is in need of (i.e.wheelchair, walker, hand splint):_______________________

____

Choose the program you feel your child will benefit best: ☐45 hours (3 hrs /day) ☐60 hours (4 hrs/day)

Parent/Guardian Signature: ____ Date: _______________________

Printed Name: ____

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Ability Plus Therapy
Each Small Step is a Giant Leap

Medical Clearance

Patient's Name: ____ Date of Birth: _______________

In the *Intensive Therapy/Suit Therapy Program* the patient participates in therapy exercises 5 days a week for 3 weeks. The exercises can cause increased heart rate, respiration and blood pressure. The patient also wears a soft orthotic called TheraSuit™ that provides increased weight bearing throughout the joints. It is comprised of several parts that are interconnected with elastic cords designed to put the body in proper alignment during exercises.

Indications: Autism Spectrum Disorder, Cerebral Palsy, Developmental Delays, Traumatic Brain Injury, Post Stroke (CVA), Genetic Disorders, Down Syndrome, Ataxia, Athetosis, Hypertonia, Hypotonia.

Contraindications to the TheraSuit: Hip Subluxations greater than 50%, Idiopathic Scoliosis, Scoliosis greater than 25°

Precautions to Intensive Therapy/TheraSuit: Heart conditions, Uncontrolled Seizure Activities, Hip Subluxation, Hydrocephalus, Diabetes, Kidney Problems, High Blood Pressure.

**** Please describe, if applicable, conditions that apply to patient:***

Heart Problems: ________________________________ High Blood Pressure: _________________________

Diabetes: _______________________________ Kidney Problems: _________________________________

Shunt: __________________________________ Fractures: _____________________________________

Degree of Subluxations: L _______ R _______ Type & Degree of Scoliosis: ________________________

Weight Bearing Restrictions (please mark): Non-Weight Bearing R L Partial Weight Bearing R L
Toe Touch R L Weight Bearing As Tolerated R L

Seizures: Controlled by Medication: YES ___ NO ___ Name of Medication: ________________________

Other Medications: ____

**** Indicate other patient conditions or precautions not mentioned:*** __________________________

____

Please check appropriate statement for this patient:

_____ This patient has the medical clearance to fully participate in the **Intensive Suit Therapy Program**.

_____ This patient has the medical clearance to participate in the **Intensive Therapy Program**; however, patient has **partial** clearance for the **TheraSuit (vest and shorts only)** **does not** have clearance for the **TheraSuit**
(indicate one)
Reason: ____

_____ This patient **does not have clearance** to participate in the Intensive Suit Therapy Program.

Reason: ____

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Physician Referral Form

Patient Name: ____ Date of Birth: _______________

Diagnosis: ____

ICD-9 Codes: ____________________________________ FL Medipass #: _____________________

INTENSIVE PHYSICAL THERAPY SERVICES REQUESTED

Evaluate and Treat

Concerns:

Orthopedic	Range of Motion	Cardiovascular
Gross Motor Skills	Strength	Sensory Processing
Mobility	Endurance	

Treatment: ______ hours per day, _____ days per week for ______ weeks, for a total of ______ hours.

**Should patient miss any time or days of his/her physical therapy for any reason, they can be made-up by adding minutes per day, days per week, and/or another week to complete the total hours stated above. ___________ (Physician initials for approval)

Office Name: ______________________________ Phone: _______________ Fax: _______________

Office Address: ____

Physician Name: ____ NPI: _________________________

Signature/Credentials of Physician: ______________________________________ Date: ___________

FL Medipass Authorization #: ____

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PLEASE INDICATE YOUR THERAPY SESSION DATE PREFERENCES

1st CHOICE: ____

2nd CHOICE: ____

3rd CHOICE: ____

Patient's Name: ____

(Every effort will be made to accommodate you on your session of First Choice. Since the center can only accommodate a limited number of patients per session, placements will be on a first come, first served basis as determined by receipt of program deposits/payments.)

Ability Plus Therapy is conveniently located in Melbourne, Florida on the Space Coast. Our clinic is ½ mile from Interstate 95, and six miles from the beautiful Atlantic Ocean. Multiple lodging facilities, restaurants, & shopping centers are nearby, with Kennedy Space Center & World Famous Ron Jon Surf Shop minutes away. Florida's entertainment attractions, (Walt Disney World, Universal Studios, & Sea World) are less than an hours drive away. We are 5 minutes from the Melbourne International Airport, and 35-40 minutes from the Orlando International Airport.

Program Cost

PROGRAM 1

45 Hours of Intensive Therapy

(3 hours per day, 5 days per week for 3 weeks)

$4,725

PROGRAM 2

60 Hours of Intensive Therapy

(4 hours per day, 5 days per week for 3 weeks)

$6,300

GENERAL POLICIES ON DEPOSITS, PAYMENTS, CANCELATIONS, AND REFUNDS

Deposit

To secure a spot for your chosen session dates Ability Plus Therapy will need to receive your **non-refundable deposit** of **$900** a minimum of **45 days prior** to the **start of session.** The **remaining balance must be received 30 days prior** to the **start of session.**

If the remaining balance is not received 30 days prior to start of session, the deposit is applied as credit towards a rescheduled session date. Short notice reservation request (less than 30 days prior to start of session) can be accommodated if there is available space. In this case, full payment for the session is due immediately.

Payments/Insurance

Personal checks, cashier's check, and credit card checks are accepted as payment. We expect full payment at the time of service.

We offer the courtesy of submitting charges to your insurance with a facilitation fee of $10 per day of service. In most cases, you will only be responsible for the portion not paid by insurance at the time of service. If your insurance reimburses you directly, we expect that the total balance be paid by you at the time of service. As a courtesy to you, we will file a claim with your primary insurance plan. If you have a second, third or fourth plan, we will provide you with the necessary papers to file your own claims.

While we will do all we can to help you in communicating and negotiating with your insurance plan, we must inform you that any balance remaining on your account that is 60 days old will be considered your responsibility and billed to you.

If you have Florida Medicaid, we will bill a total of 9 hours as allowed by Medicaid. Patient is responsible for the remaining hours not covered by Medicaid (36 hours for the 45 hour program, and 51 hours for the 60 hour program).

We expect that patients due balances will be paid upon receipt of our statement. If your account is 30 days past due from the date of our statement, a monthly late payment charge of 5% of the total amount due will be applied. If payment is not received within 90 days of date of statement, your account will be sent to a collection agency, and all costs of this process will be your responsibility.

Cancellation

A $75 cancellation fee will be assessed for each cancellation of a reserved spot less than 30 days prior to start of session. This amount will be charged against your total account balance. The $75 cancellation fee is waived if you cancel and reschedule before the 30-day full payment due date. Your entire deposit and payment will be applied as credit to a rescheduled session date. A cancellation to reschedule must be received in writing and sent via mail or email to Ability Plus Therapy.

The $75 cancellation fee is waived if your child becomes ill before the session starts and is not able to attend or your child's physician does not recommend the intensive therapy. Your entire deposit and payment will be applied as credit to the new session date. A cancellation to reschedule due to child's illness will require documentation from your child's physician be forwarded to us.

If you cancel your child's session within 7 days of the start of the session, for reasons other than emergency, your deposit will not be applied as a credit to a rescheduled session date. If you do not show up for your session, your deposit will also not be applied to a rescheduled session. Another $900 deposit will be needed to secure your rescheduled session.

Refunds

The $900 deposit is non-refundable. Refund of the remaining balance in your account will be issued if you decide to cancel completely. A refund check will be issued within 30 days. The cancellation must be made in writing and sent to us by mail or email.

Please note that the $75 cancellation fee will apply if you cancel completely less than 30 days before a reserved session date. This amount will be charged in addition to the non-refundable deposit.

Make-up Session

If your child becomes ill during the session and misses consecutive days of therapy that amount to at least 30% of the three-week session, we will discuss with you how your child can "make-up" for the days of missed therapy. If you are late to arrive for a session, or you do not show to a session without notifying us prior to the scheduled appointment, other than for an emergency, the missed time will not be made up, nor will the cost of that time be refunded. This time also cannot be submitted to your insurance company for reimbursement.

X____
Parent or Guardian's Signature

X____
Parent or Guardian's Name (Please Print)

Date ________________________

Date: ______________

PATIENT INSURANCE INFORMATION:

Patient's Full Name: ____

Date of Birth: ___________________ Social Security No.: ___________________________________

Address: ____

City: ____

State: _______________ Zip: _______________________ Country: ________________________

Parents' Name: ____

Home Phone: ___________________________ Cell Phone: __________________________________

Email: ____

INSURANCE SECTION:

Primary Insurance Co: ____

Policy/ID No of Patient: ____

Group No: ____

Claims Address: ____

____ Phone Number: ____________________________

Policy Holder's Full Name: ____

Policy Holder's Date of Birth: ____

Policy Holder's Social Security No: ____

Employer's Name:____

Please include front & back copy of insurance card
Fax back information to start process for Insurance Pre-approval to: 321-253-9777

Checklist of Forms and Reports Needed in Addition to Your Deposit of $900:

- ☐ Patient Information Form
- ☐ Report from Physical Therapist, Occupational Therapist, Pediatrician, Orthopedist, Neurologist, etc.
- ☐ Latest hip X-ray report
- ☐ Latest spine X-ray report
- ☐ Medical Clearance Form signed by the physician
- ☐ Therapy Session Date Selection Form
- ☐ General Policies Form
- ☐ Insurance Information Form

Mail or Fax them to:
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Fax: (321) 253-9777