



A New Beginning Health Services LLC

Where Children Flourish and Dreams take Flight

3200 Cobb Galleria Parkway, suite 228
Atlanta, GA 30349

Dear Parent,

Thank you for your interest in our Intensive Therapy Program which utilizes the TheraSuit Method™ and Universal Exercise Unit to facilitate strengthening, learning of motor movement patterns, and provide vestibular input. The TheraSuit Method™ is used for the following diagnoses: cerebral palsy, developmental delays, traumatic brain injury, post stroke, ataxia, athetosis, spasticity and hypotonia. For specific information regarding the TheraSuit Method™, you can call 404-814-7166.

To be considered for our Intensive Therapy Program, you will need to provide us with specific information and fully complete the required forms which will provide us with the requisite information to determine if our program is appropriate for your child.

*****IMPORTANT:** A Hip and Spine x-ray along with the report dated within the past year is required. Please relay to the doctor that the percentage or degree of hip subluxation and spine curvature needs to be indicated on the x-ray report. The Intensive Therapy Program schedule is 3 hours daily, 5 days per week, for 5-6 weeks. During this time, your child will receive 1:1 session using the TheraSuit Method™.

A \$100 deposit** is required to reserve the desired dates for your child's session. Upon receipt of the required deposit, your child's program dates will be confirmed. The deposit will be returned when the program starts if your child has Peachstate, Amerigroup or Medicaid. If you have private insurance, the deposit can be used for co-pays, deductible and co-insurance. If you have any questions or would like additional information, please feel free to contact us. We look forward to hearing from you. Thank you for your consideration of our clinic.

Please complete the following documents and email it back to us prior to your first treatment session. Please email forms to anewbeginningpt@gmail.com

- Attendance Policy
- New Patient Demographic Info
- Photo/Video Consent & Release Form
- Therapy Consent Form



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Attendance Policy

If your child experiences a medical emergency or an event that requires advanced medical treatment during their scheduled session, the remaining hours that they were scheduled to attend can be carried forward to a future available session.

In case your child needs to miss the session due to an illness, **a doctors note is required to justify the absence from the program.**

Once you have signed up for the schedule and started the program, we are not able to adjust to allow for another child to benefit from an uncompleted slot.

I agree and understand the policies stated above.

Parent/Guardian Name _____ Date _____
Signature _____



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A New Beginning Health Services LLC provides a specialized intensive exercise program for children with developmental, neurological, sensory, mental, orthopedic, and other types of disabilities. As one might expect, there is some element of risk involved with any physical activity/exercise, an intense exercise program, and the use of all exercise equipment (including the TheraSuit & the Universal Exercise Unit). Although the risk is greatly reduced by the use of safety equipment, proper supervision, appropriate training, and skilled therapists, there still remains the risk of injury during participation in the clinic's activities.

Therefore, it is necessary to get your permission to allow:

(Print child's name)

to participate in the exercise program provided by A New Beginning Health Services LLC .

I, _____

A New Beginning Health Services LLC from any liability, claims, demands, and causes of action,

now or in the future, resulting from soreness or injury regardless of cause, occurring during or after my child's participation in the exercise program/suit training session.

By signing this Consent for Participation/Informed Consent Waiver, I hereby affirm that I have fully read the above statement and understand the inherent risks involved with participation in A New Beginning Health Services the exercise program/suit training session and give permission for my child to participate.

Parent or Guardian Signature Date

Print Parent or Guardian Name: _____

Address: _____

Phone #: _____

Photo/Video Consent & Release Form



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A New Beginning recognizes the need to ensure the welfare and safety of all individuals taking part in any activity associated with our company. In accordance with our protection policy we will not permit photographs, video or other images of a minor be taken without the consent of the parent/guardian.

As your child will be taking part in the Intensive therapy here at our facility, we would like to ask for your consent to take photographs/videos for the following purposes:

- * **Record of therapeutic progress**
- * **Home exercise program**
- * **Marketing via social media (Facebook, Instagram, and/or our company website)**
- * **Records of activities or events in published material.**

A New Beginning Health Services LLC will take all steps to ensure these images are used solely for

the purpose they are intended for. If you become aware that these images are being used inappropriately, we ask that you please notify our staff immediately.

I hereby authorize A New Beginning Health Services LLC to use photographs and video taken of myself or my minor child during exercise sessions at A New Beginning Health Services LLC in educational, informational and promotional materials.

I understand that A New Beginning Health Services LLC serves as a training facility and at times other therapists or interns may be observing, handling, or have access to my child's medical information. I give my permission for the above interaction to take place for educational purposes.

Please initial and sign.

I Consent _____

I Do Not consent _____

Name of person photographed: _____

Signature: _____ Date: _____

(parent's signature if under 18)



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New Patient Demographic Info

Child Name: _____

Preferred Name: _____ DOB: _____

Age: _____

Gender: (circle one) Male / Female / Neutral

Home Address: _____

City: _____

State: _____ Zip: _____

Parent/Guardian #1: _____

Relationship to child: _____

Home Number: _____

Cell Number: _____

Email Address: _____

Occupation: _____

Parent/Guardian #2: _____

Relationship to child: _____

Home Number: _____

Cell Number: _____

Email Address: _____

Occupation: _____

Who has legal custody of the child?: (circle one) Parent/Guardian #1 / Parent/Guardian #2 / Both Parents



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Primary Insurance: _____

Provider Services Phone Number: _____

Policy Holder Name (if different from child): _____

DOB: _____

Member ID#: _____

Group #: _____

Claims

Address: _____

Secondary Insurance: _____

Provider Services Phone Number: _____

Policy Holder Name (if different from child): _____

DOB: _____

Member ID#: _____

Group #: _____

Claims Address:

Primary Care Doctor: _____

Phone Number: _____

Practice Location Name:

Practice Location Address:

How did you hear about us?:

Health Information

PLEASE ANSWER ALL QUESTIONS AS THOROUGHLY AS POSSIBLE SO WE
HAVE A BETTER UNDERSTANDING OF YOUR CHILD'S NEEDS.



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WHAT IS YOUR CHILD'S DIAGNOSIS: _____

MEDICAL / SURGICAL HISTORY: _____

* HISTORY OF BOTOX / PHENOL INJECTIONS _____

* HISTORY OF INHIBITIVE / SERIAL CASTING (DATES)

* HISTORY OF FRACTURES

WHAT IS YOUR CHILD'S:

HEIGHT _____ WEIGHT _____

SHOE SIZE WITH BRACES _____

SHOE SIZE WITHOUT BRACES _____

CIRCUMFERENCE MEASUREMENT OF:

CHEST _____ WAIST _____ THIGH _____

MEDICAL STATUS:

* SEIZURES (date of last one)

* SCOLIOSIS (degrees & direction)

* HIP (degree)

* HEART PROBLEMS / HYPERTENSION / PAST HEART SURGERIES

*ALLERGIES

MEDICAL STATUS CONTINUED:



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- * LUNG PROBLEMS
- * DIABETES
- * VISION / HEARING
- * SHUNTS (hydrocephalus)
- * TRACHEAL / G-TUBE
- * KIDNEY PROBLEMS

LEG LENGTH DISCREPANCY? PLEASE PROVIDE ACCURATE MEASUREMENTS.

RIGHT LEG: _____

LEFT LEG: _____

PLEASE PROVIDE NAMES & PHONE NUMBERS FOR ALL SPECIALISTS WHO TREAT YOUR CHILD.

1. _____
2. _____
3. _____
4. _____
5. _____

PLEASE LIST ANY MEDICATIONS YOUR CHILD IS CURRENTLY TAKING ALONG WITH THE CONDITION THE MEDICATION TREATS:



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CHILD'S ABILITIES (rolling, sitting, crawling, and walking):

LIST OF MEDICAL EQUIPMENT YOUR CHILD IS USING:
(braces, walker, crutches, wheelchair)

HOW DO YOU COMMUNICATE WITH YOUR CHILD / HOW DO THEY
COMMUNICATE WITH YOU?

IS YOUR CHILD ABLE TO FOLLOW SIMPLE COMMANDS?

HAS YOUR CHILD EVER RECEIVED INTENSIVE THERAPY?
(IF YES, PLEASE LIST DATE AND LOCATION)

HAS YOUR CHILD BEEN ADVISED AGAINST EXERCISING? (WHEN & WHY)
PLEASE COMMENT BELOW ON YOUR CHILD'S HABITS:

EATING HABITS:

WATER / FLUID INTAKE:

TIME OF DAY THAT YOUR CHILD NAPS:

WHAT ARE YOUR GOALS FOR THE INTENSE
THERAPY _____

****PLEASE PROVIDE A WRITTEN HIP AND SPINE X-RAY REPORT DATED
WITHIN THE PAST YEAR ** THANK YOU!**