



NEW CLIENT PACKET

DEMOGRAPHIC INFORMATION

Child's Name: _____ Male Female Date of Birth: _____ Date: _____

Parents/Care-givers: _____ Occupation/Employer: _____
Mother's Name

_____ OccupationEmployer: _____
Father's Name

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____
Street City/State Zip Code

Primary Insured on Insurance Policy: _____ DOB: _____ SS# _____

Emergency Contact Name: _____ Emergency Contact Number: _____

Email: _____ Referred by: _____

Current Concerns/Reason for Referral: _____

How did you hear about us?: _____ Internet _____ Friend- _____
_____ Referring Doctor- _____ Other- _____

MEDICAL INFORMATION:

Primary Care Physician: _____ Physician Phone _____

Physician Fax: _____

Does your child currently see other Specialists? (Physicians, Counseling, Tutoring, etc): please list name and contact number. Also please list previous therapies or services your child has received and the approximate dates he/she received them.

SOCIAL/ EDUCATIONAL HISTORY:

School/Day Care: _____ Phone: _____ Grade: _____

What do you see as your child's strengths academically? _____

What activities does your child enjoy? _____

How does your child interact with others? (out-going, friendly, shy, aggressive, cooperative) _____

CURRENT CONDITION:

Child's health: (good, fair, poor) _____ Child's current weight: _____ Child's Current height: _____

Current Condition Continued:

Date of last physical exam: _____ Date of last hearing evaluation: _____ Results: _____

Is your child currently taking any medications?(if "yes" please list medication name, dosage, and frequency): _____

Allergies: (foods(peanuts), medications, environment, etc) _____

Does your child sleep / nap well? Yes No Sometimes Comments: _____

Does your child participate in age appropriate movement activities (e.g. riding a bike, skipping)?

Yes No Sometimes Comments: _____

At what age did your child gain bowel control? _____ Bladder Control? _____

Describe you child's current demeanor/behavior: _____

DEVELOPMENTAL HISTORY

MATERNAL HISTORY

Was mother's pregnancy full-term? Yes No Comments: _____

Were there any drugs or medication taken during the mother's pregnancy? Yes No Comments: _____

Were there any accidents or injuries during pregnancy? Yes No Comments: _____

Were there any complications with labor or delivery? Yes No Comments: _____
(labor induced, c-section, vacuum suction, forceps, etc.)

CHILDS BIRTH

Birth Weight? _____ Apgar Scores: _____ Any other complications: (i.e. seizures, jaundice, need for oxygen, stay in NICU, congenital abnormalities, etc.) _____

DEVELOPMENTAL MILESTONES Please list what age (in months) that your child achieved the following:

Roll _____ Sit unsupported _____ Crawl _____ Walk _____ Go up/down stairs _____ Run _____

Began saying words _____ Finger feed _____ Use spoon _____ Drink from cup _____ Dress Independently _____

Use 2-3 words together? _____ Does/Did your child "W" sit? _____ Yes _____ No

Do you feel your child has lost any skills? _____ Yes _____ No If yes, what skills and when were they lost?

History of any major illnesses or hospitalizations? _____

Are there any diagnosed mental, physical or emotional disabilities? _____

FEEDING / ORAL MOTOR HISTORY

Was your child breast fed? Yes No Comments: _____

Was your child bottle fed? Yes No Comments: _____

Does your child demonstrate any of the following difficulties with feeding/oral motor skills skills?

- Over-stuffs their mouth with food
- Gags/Vomits during feedings
- Frequently Drools
- Strong food preferences
- Limited Diet
- Special Diet
- Avoids face washing / tooth brushing
- Difficulties with chewing skills

Spillage of food/drinks from their mouth Difficulties using cup and/or straw Food texture preferences (if so, please describe; crunchy, smooth, warm, cold, etc.) _____

Does your child have a history of Reflux? Yes No Comments: _____

Self Help Skills:

	Independent	Help Needed
Dressing: Socks/Shoes		
Shirt		
Pants		
Tying Shoes		
Bathing		
Tooth brushing		
Toileting		
Dresses in a timely manner		
Feeding: Use of cup		
Use of spoon		
Use of fork		
Chews and swallows well		
Eats a variety of foods and textures		

Please use space below for any additional comments: _____

SPEECH AND LANGUAGE CONCERNS

Current Concerns:

- Articulation Skills: (child is difficult to understand?) _____
- Expressive Language Skills: (unable to communicate their thoughts verbally/clearly?) _____
- Receptive Language Skills: (unable to follow directions, understand concepts/commands?) _____
- Hearing Skills (hearing loss, appears to not hear what you are saying?) _____
- Oral Motor Skills (strength is poor, frequent drooling?) _____
- Swallowing / Feeding Skills (difficulties with chewing, chokes/gags frequently?) _____
- Any other concerns? _____

How does your child communicate with you and others? (gestures, single words, sentences) _____

What language(s) does your child speak? _____

What language(s) are spoken in the home? _____

Is there a family history of speech-language delays/disorders, learning disabilities, or other developmental delay? Yes

No Comments: _____

What are your concerns regarding your child's speech and language development? _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize OT Connection to release medical information to my private insurance carrier as is required for determination of benefits. I also authorize payment of medical benefits to the undersigned physician or supplier for services described below.

*

Signature of legal representative of child

Date

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment below. This authorization will stay in effect until revoked by me.

*

Signature of legal representative of child

Date

I also allow the release of my child's medical information to the following physicians and/or additional professionals indicated:

Physicians Name: _____ Additional Professional Name: _____

This authorization is valid for the duration of my child's treatment from the date signed below. I understand that I may revoke this authorization at any time, but will not hold OT Connection responsible for already releasing information in good faith.

OT Connection is released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

*

Signature of legal representative of child

Date

CONSENT FOR CARE AND TREATMENT: As the child's parent or legal guardian, I hereby grant permission for the licensed therapists at OT Connection to render to my child routine therapeutic care including evaluations, therapeutic activities, educational activities, and other procedures and/or treatments prescribed by my child's therapist as is necessary in their judgment. I understand that my child is under the care and supervision of my therapist.

*

Signature of legal representative of child

Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: I acknowledge that OT Connection will use and disclose my personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. I understand that I may request a copy of the Notice of Privacy Practices to provide further detailed information about how we use and/or disclose protected medical information about your child for treatment, payment, healthcare operations, and as otherwise allowed by law.

*

Signature of legal representative of child

Date

CONSENT FOR PARENT OBSERVATION: I understand that other parents may observe my child in therapy as the parents observe their child in therapy.

I consent to the presence of other parents in the same treatment area with my child as the parents observe their child in therapy.

I do not consent to have other parents in the same treatment area as my child.

*

Signature of legal representative of child

Date

Notice of Financial Responsibility

- OT Connection will file insurance claims with any insurance carrier. We are currently in-network with: PHCS, Humana, BCBS, Superior Healthcare, Aetna, Amerigroup, Health Smart, Great West, Tricare, and Medicaid Plans. All parents are expected to know and understand their coverage and benefits for therapy services. Although we will verify insurance benefits prior to your first appointment, you may also check your benefits by calling the phone number on your insurance card and speaking with a representative from the insurance company. It is very important that you ask specifically about any "exclusions" or "limitations" to therapy benefits. A quote of benefits from your insurance company is not a guarantee of payment. In the event your insurance chooses not to pay for services, you are ultimately responsible for all charges.
- Please provide OT Connection with a copy of your insurance card each time you receive a new card and/or your insurance information changes. Please understand that if your insurance company delays payment or is waiting on additional information before they render payment, and the balance due is past 60 days, the balance is your responsibility and is due immediately.
- If we are not filing insurance for you, payment for services is due at the time of service.
- We will do our best to answer any insurance related questions. However, calling your insurance company directly is frequently required. Any follow-up regarding non-payment after our initial appeals process is your responsibility. **If payment is not issued by the insurance company within 60 days of initial filing, you are responsible for payment IN FULL for all services rendered. It is then your responsibility to follow up with the insurance company regarding any further appeals.**
- **Co-payments are to be paid at the time of service.**
- **Any portion of the therapy fees not reimbursed by your insurance company is your responsibility.**
- Insurance companies use procedure codes to process your claim. These codes are referred to as units. Some insurance companies have limits on the number of units they will pay per visit. The initial evaluation and the re-evaluation may exceed the number of units allowed through some insurance plans. It is the client's responsibility to pay for any portion of the evaluation or re-evaluation not reimbursed by the insurance company.
- You are responsible for payment of any no-show cancellations. Please see the cancellation charges section on your fee schedule for specific details.
- Any balance left unpaid by insurance company after 60 days, is the responsibility of the client. At this time, if payment is not made immediately, services will be placed on hold until the balance is paid in full.

I authorize OT Connection to keep my signature on file and to charge my account for balance of charges not paid by insurance within 60 days and not to exceed \$ _____.

Circle One: Visa Master Card American Express Discover

_____ This visit only _____ All visits this year _____ Co-Payments _____ No show or late cancellation charges
_____ All of the above

Cardholder's Name: _____ Cardholder's Signature: _____
Account Number: _____ Expiration Date: _____
3-digit Security Code: _____

FINANCIAL RESPONSIBILITY

I have read the above and hereby accept all responsibility for the evaluation and treatment costs incurred by my child. The undersigned certifies that he/she has been provided the evaluation and treatment costs and is the responsible party and accepts these terms.

Responsible Party's Signature: _____ Date: _____

PHOTOGRAPH RELEASE: I hereby authorize OT Connection to photograph and/or video-tape my child for the purposes of treatment, education, and professional reasons.

- I consent to my child being photographed and/or video-taped.
- I do not consent to my child being photographed and/or video-taped.

Signature of legal representative of child

Date

GENERAL GUIDELINES

The following information is a list of general guidelines that will assist in creating a treatment environment that is as efficient and smooth as possible. If you have any questions, please speak with your therapist.

1. Please have your child dressed in comfortable clothing that may get dirty during therapy.
2. If you want to observe the treatment session, please discuss this with your therapist first. Due to the HIPAA privacy laws there is a specific procedure that must be followed to ensure the privacy of other clients in our therapeutic setting.
3. The last few minutes of your child's session will be used to discuss your child's progress in therapy and review any home activities the therapist recommends. Please keep in mind our therapists have very busy schedules and be respectful of their time by bringing your discussions to an end by the top of the hour. If you have additional questions or would like to discuss your child's progress further, please email or call the therapist. If you feel you need a significant amount of time to talk to your child's therapist, you may schedule a consultation appointment with your therapist. The charge for this appointment is \$40.00/30 minutes. This fee is due from you at the time of the appointment and will not be billed to insurance. This appointment is also subject to our cancellation policy.
4. If you are running late for an appointment, please call and let your therapist know. It may be possible to extend your time, depending on scheduling.

ATTENDANCE / CANCELLATION POLICY

- If you must cancel an appointment, please do so by giving 24 hours notice. We do encourage rescheduling your appointment if possible. It is essential to keep a regular schedule for any treatment to be successful. Understanding that emergencies do occur, it is our policy that any **cancellation with less than 3 hours notice** will result in a charge of **\$50.00**. These charges are not reimbursable by your insurance company and must be paid at the time of your next scheduled therapy appointment.
- If you do not show up or "NO-SHOW" for your appointment and do not give notice, you will be charged the rate of **\$50.00**. These charges are not reimbursable by your insurance company and must be paid at the time of your next scheduled therapy appointment.
- Three "no show" cancellations, missing more than 50% of the scheduled treatment sessions, or habitual cancellations will result in the loss of a reserved treatment time slot and/or your child being discharged from therapy.
- You will be notified as far in advance as possible when your therapist is ill, on vacation or attending a continuing education conference. Every effort will be made to reschedule your appointments so that your child will miss as little treatment as possible.
- If you choose to leave the clinic during your child's therapy appointment, please be prompt in picking up him/her when their session is over as we do not have means for childcare. Please return 15 minutes before the hour and if you arrive after the top of the hour a fee of \$1.00 per minute will be due. Please leave all current contact information in case of any emergencies with your therapist or our front office staff upon leaving.

Signature of legal representative of child

Date