



NEW CLIENT PACKET

Date: \_\_\_\_\_

**DEMOGRAPHIC INFORMATION**

Child's Name: \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/State Zip Code

Primary Insured on Insurance Policy: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

**Parents/Care-givers**

Mother's Name:	Father's Name:
Employer:	Employer:
Email:	Email:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:

Emergency Contact Name: \_\_\_\_\_ Emergency Contact Number: \_\_\_\_\_  
(Other than Parents)

Current Concerns/Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did you hear about us?: \_\_\_\_\_ Internet \_\_\_\_\_ Friend \_\_\_\_\_  
\_\_\_\_\_ Physician \_\_\_\_\_ Other \_\_\_\_\_

**MEDICAL INFORMATION:**

Primary Care Physician: \_\_\_\_\_ Phone \_\_\_\_\_ 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: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_ Date of last hearing evaluation: \_\_\_\_\_ Results: \_\_\_\_\_

Number of Ear Infections: \_\_\_\_\_

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, other- \_\_\_\_\_

**CHILD'S 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/downstairs \_\_\_\_\_ Run \_\_\_\_\_

Began saying words \_\_\_\_\_ Finger feed \_\_\_\_\_ Use spoon \_\_\_\_\_ Drink from cup \_\_\_\_\_ Dress Independent \_\_\_\_\_

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:**

	<b>Independent</b>	<b>Help Needed</b>
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? \_\_\_\_\_



## Notice of Financial Responsibility



Please initial next to each item and sign at the bottom.

- \_\_\_\_\_ OT Connection will file insurance claims with any insurance carrier, but we do not file to secondary insurance. We are currently in-network with: Aetna, BCBS, Cigna, Humana, Superior Healthcare, Tricare, United Health Care and Medicaid. **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 for any reason 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 you do not notify us that your insurance has changed then you will be responsible for the balance, and re-filing all retro claims to the correct insurance.**
- \_\_\_\_\_ Deductibles, co-insurance and co-payments are due at the time services are rendered. **Any portion of the therapy fees not reimbursed by your insurance company is your responsibility.** 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.
- \_\_\_\_\_ 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.**
- \_\_\_\_\_ **Insurance companies frequently request your medical records for review. The insurance company then puts your claims on hold for review. Due to the frequency of these requests, and the time it takes insurance to complete this process, you will have the option of continuing therapy at the contracted rate we have with your insurance or discontinuing services until the claims have finalized for payment. If you choose to pay for sessions during this process, and your insurance makes payment then we will reimburse you for those payments minus any patient portion.** All billing/statement questions should be addressed to Amy Hart, our office/billing manager via email at [amy@otconnection.com](mailto:amy@otconnection.com) or you may reach her at 512-251-3230.
- \_\_\_\_\_ Most insurance policies have a visit limitation. Once this limit has been reached your benefits have been exhausted, and insurance will deny all additional sessions. At that time you may choose to continue therapy at our fee for service rate. **You are responsible for tracking your visit limit.** OT Connection is not responsible for tracking or notifying you when this limit has been reached. Any sessions denied for exceeding your visit limit will be the financial responsibility of the guarantor on your child's account.
- \_\_\_\_\_ 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 or short notice cancellations. Please see the cancellation charges section on your fee schedule for specific details.
- \_\_\_\_\_ In the event that a check is returned for insufficient funds, there will be a fee of \$35.00 due on your account in addition to the original balance.
- \_\_\_\_\_ Any accounts turned over to our outside collection agency will incur an additional charge of 33% on your balance for administrative fees.

### 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: \_\_\_\_\_

## 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 leave a message for the therapist, and they will be more than happy to discuss at your child's next therapy session. 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 \$50.00/30 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. For your convenience, OT Connection allows parents/legal guardians or caregiver to leave the clinic during their child's appointment. However, it is very important to be back at the clinic 15 minutes before the patient's appointment is scheduled to end so the therapist can discuss treatment. If tardiness becomes a recurring issue, we will require the parent/legal guardian or caregiver to stay during the patient's treatment.

**OT Connection must have a cell phone number to reach you before you leave the clinic.**

## THERAPY ATTENDANCE EXPECTANCE

**We value your child's progress in therapy and consistent attendance equals consistent progress!**

**Please initial next to each item and sign at the bottom.**

- \_\_\_\_\_ • 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. Please note that if we receive less than 24 hours notice there will be a **\$50 short notice cancellation fee applied to your account.** These charges are not reimbursable by your insurance company and must be paid at the time of your next scheduled therapy appointment.
- \_\_\_\_\_ • If you must cancel or reschedule an appointment please contact the Front Desk, Neaomi at [Neaomi@otconnection.com](mailto:Neaomi@otconnection.com) or by phone: 512-251-3230. Voicemails may be left 24 hours a day. Please notify **ONLY** the front desk of any cancellations, notifying your therapist and not the front desk will still result in a \$50.00 no-show fee. All emails and voicemails will be returned to confirm the cancellation. **If you do not receive a confirmation from the front office, your appointment has not been cancelled and you will be charged the \$50.00 no-show fee.**
- \_\_\_\_\_ • **If you do not show up or "NO-SHOW" for your appointment and do not give notice, you will be charged a fee of \$50.00.**
- \_\_\_\_\_ • Prompt, regular attendance is key to a successful outcome for your child's therapy. Be advised that if you arrive to your appointment 10 minutes or more late, your appointment time for that day will need to be re-scheduled and there will be a \$50.00 fee for this missed appointment. These charges are not reimbursable by your insurance company and must be paid at the time of your next scheduled therapy appointment.
- \_\_\_\_\_ • **Two "no show" cancellations, missing more than 20% 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.

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Signature of legal representative of child

Date



**Authorization for Emergency Care to Minor**

Hospital to be taken to in case of an emergency: \_\_\_\_\_

**In case of emergency illness or accident the child is given first-aid and the parents are notified. If the parents or the child's doctor cannot be located, the child will be taken to the Emergency Room of your choice.**

**OT Connection does not assume responsibility for the payment of hospital, doctor or ambulance fees.**

I/We the undersigned, parent(s) or legal guardian of the minor listed below:

(List Name of Minor) \_\_\_\_\_ do hereby authorize any administration of emergency medication by **OT Connection**, x-ray examination, anesthetic, dental, medical or surgical diagnosis or treatment by any physician or dentist licensed by the State and hospital service that may be rendered to said minor under the general, specific, or special consent of an acting agent of **OT Connection**, the temporary Custodian of the minor, whether such diagnosis or treatment is rendered at the office of the physician or dentist, or at a hospital licensed by the State. I/We authorize the physician or dentist to call in any necessary consultants, in his/their own discretion. We further authorize said physician or dentist to exercise his /their discretion in authorizing the disposal of any severed tissues or member. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage those persons who have temporary custody of the minor and said physician or dentist to exercise his/their best judgment as to the requirements of such diagnosis or medical or dental or surgical treatment. This consent shall remain effective for the duration of the patient's treatment at OT Connection unless sooner revoked in writing, delivered to said physician or dentist of the said Persons entrusted with the custody, care and control of said minor children.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**OT Connections Staff Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**General Consent Form to the Use and Disclosure of Protected Health Information**

I understand that **OT Connection** creates and maintains medical and related records that include personal healthcare information, including health records, symptoms, demographic information, diagnoses, examination and test results, treatment, and any plans for future care or treatment. This is “protected health information”.

I understand and consent to the use and disclosure of Health Information by **OT Connection** for the following purposes:

- **Treatment:** This includes the provision, coordination, or supervision of healthcare and related services, including the coordination or management of care and consultation between healthcare professionals related to treatment, or referral to another healthcare professional.
- **Payment for healthcare services provided:** This includes actions undertaken by a health plan to decide coverage or the provision of benefits, by Provider or a health plan to obtain or provide compensation for care.
- **Provider's internal operations:** This includes quality assessment and improvement activities; reviewing provider performance and training; activities relating to health insurance and benefits; conducting or arranging for medical review, legal services, and audits; business planning and development; and business management and general administrative activities including customer service, resolution of internal grievances, due diligence, and creating de-identified healthcare information.

I understand and agree that:

- I have the right to request restrictions as to how Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand and agree that Provider is not required to agree to any restrictions that I may request, but if Provider agrees, it will be bound by that restriction.
- I have the right to revoke this Consent by notifying **OT Connection** *in writing* that I revoke this Consent unless **OT Connection** has used or disclosed Health Information in reliance on this Consent.
- **OT Connection** has the right to disclose relevant Health Information to family member, other relative, close personal friend, or anyone identified by me.

\_\_\_\_\_  
**Signature of Parent or Guardian**      **Date**

\_\_\_\_\_  
**Printed Name of Patient**      **Date**

\_\_\_\_\_  
**OT Connection Staff Witness**      **Date**



**Authorization to Release Protected Health Information**

I consent to the release of information and/or disclosure to **OT Connection** of all or any part of my child's medical record by any physician, hospital or other facility of which my child has been a patient; and release of information by **OT Connection** to individuals acting as my authorized representative (guardian, or attorney in fact pursuant to a power of attorney), as required to governmental agencies, accrediting bodies or other health care providers involved in my child's care including any successors of **OT Connection**.

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

Signing in the capacity of **(circle one)**:

Parent                      Court appointed legal guardian Health Care Proxy

**I authorize OT Connection and its agents to disclose information related to my child's care to the following persons upon request:**

Name/Relationship: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Patient or Authorized Representative Signature)

**OT Connection Representative :** \_\_\_\_\_

**Date:** \_\_\_\_\_

# **!!!!!!! Benefits Update For 2012 !!!!!!!**

**Please be advised that although we will continue to check eligibility, deductibles, and co-pay amounts with your insurance company this year we are no longer checking specific diagnosis codes for coverage. This coverage varies on every policy so please be sure to contact your insurance for detailed benefit information and exclusions that apply to your policy. All benefits quoted are based on an estimate we receive from your insurance company, and are not guaranteed. Any visits that are not covered by your insurance policy due to visit limitations, exclusions on your policy such as non-covered diagnosis codes or age limits, therapy not deemed medically necessary per your policy or insurance policies that term will be the financial responsibility of the guarantor on your child's account.**

**Although we check to see if there is a visit limit on your policy you will be responsible for tracking the number of visits your child has used, and letting us know if you wish to continue with services beyond that limit. OT Connection will not be responsible for tracking your policy visit limit.**

**Please remember that we require at least 24 hours notice if your insurance has changed. If we do not receive this notice then we will require the cash rate deposit for your visit until we can verify eligibility and benefits on the new policy.**

**If your insurance requires medical review before claims are paid then we will require a deposit equal to the contracted rate we have with your insurance until claims finalize for payment. Appointments can't be held for patients unable to attend therapy during medical review process.**

**We post all payments received from insurance by the 10<sup>th</sup> of the following month, and close out the previous month on the 15<sup>th</sup> of the following month. All credits on accounts will be refunded by the end of the last week of the following month as long as there are not any outstanding balances due on your account at that time.**

**If you require itemized receipts please request these from the front desk at the time of your appointment, and we will be happy to email these to you free of charge. If you request itemized receipts on a monthly or yearly basis there will be an administrative fee of \$25.00. Once we receive your request, and payment is received we will have 14 business days to provide this documentation.**

**These updates are in addition to the financial policies, and attendance agreements that you received in your new client paperwork. If you have any billing/insurance questions please email them to [amy@otconnection.com](mailto:amy@otconnection.com) or you can leave me a voicemail. Email is the best way to reach me, but all calls and emails will be returned within 2 business days. If I am out of the office then I will contact you within 2 business days upon my return.**

**Amy Hart  
Office/Billing Manager  
[amy@otconnection.com](mailto:amy@otconnection.com)  
512-251-3230**

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**Patient Name/ Date**

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**Parent Name/ Date**

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**OTC Staff Signature**

# OT CONNECTION FOOD ALLERGY WAIVER

On occasion we use snacks as part of your child's therapy session. Please sign below if you consent to your child receiving and consuming snacks during their therapy session.

My child \_\_\_\_\_ **HAS MY PERMISSION** to receive snacks from OT Connection  
Patient Name

during treatment sessions. \_\_\_\_\_  
Parent/Guardian Name

My child \_\_\_\_\_ **DOES NOT** have my permission to receive snacks from  
Patient Name

OT Connection during treatment sessions. \_\_\_\_\_  
Parent/Guardian Name

**We are committed to providing a safe atmosphere for our patients so please list all of your child's known food allergies below.**

My child \_\_\_\_\_ **has NO known food allergies.** \_\_\_\_\_  
Patient Name Parent/Guardian Name

My child \_\_\_\_\_ has the following known food allergies or restrictions:  
Patient Name

**Please list specific foods such as gold fish, candy, gluten free...etc, that you DON'T want your child to consume based on allergies or diet restrictions.**


\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Parent/Guardian Signature/Date

\_\_\_\_\_  
OTC Staff Signature