Exceptional Kids Deserve Exceptional Care

# New Client Form

## Client General Information

| | | | | | | |
|---|---|---|---|---|---|---|
| **Date: / /** | **OT** ☐ | **PT** ☐ | **ST** ☐ | **OT4KIDS ID#:** | | |
| **Client's Name:** | | | | **DOB: / /** | **M** ☐ | **F** ☐ |
| **Address:** | | **City:** | | **State:** | **Zip:** | |
| **Legal Guardian:** | | | | | | |
| ***Circle relationship of legal guardian:*** **◯Parent ◯Grandparent ◯Kinship ◯Foster Parent ◯Other (Specify): _____** | | | | | | |
| **Cell Phone:** | | **Home Phone:** | | **Work Phone:** | | |
| **Email Address:** | | | | | | |
| **Emergency Contact (*if different from above*):** | | | | | | |
| **Relationship to Patient:** | | | | **Phone Number:** | | |
| **Allergies/ Special Diet:** | | | | | | |
| **Primary Physician/Office:** | | | | **Phone Number:** | | |
| **Address:** | | | | **Fax Number:** | | |

**How did you hear about OT4KIDS Inc.? _____**

**Has the client received occupational (or other) therapy in the past? Yes / No**

**If yes, please list details (therapist(s), date(s), location(s), etc...) _____**

_____

**Does the client currently receive any other therapy? Yes / No**

**If yes, please list details (therapist(s), date(s), location(s), etc...) _____**

_____

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# Client Demographic Information

**What is the primary language(s) spoken at home?** _____

**Is the client adopted?** _____ **Should we disclose information about the adoption to the client?** _____

**Who lives at home (mother/father, siblings, grandparents)?** _____

_____

**List any legal guardians who do not live in the same home as the client:** _____

_____

**Does the client attend public school, private school, home school or daycare? If yes, specify**_____

**Name of school:** _____ **Grade:** _____ **Teacher's name:** _____

# Client Insurance Information

## Primary Insurance Information:

**Insured's Address if different:** _____ **Effective Date:** _____

**Insured Member's Name:** _____ **SS#:** _____

**Insured's Employer:** _____ **DOB:** _____/_____/_____

**Insurance Carrier:** _____ **Plan Type (PPO, Blue E, etc.):** _____

**Member or Medicaid ID#:** _____ **Group #:** _____

**Insurance Mailing Address:** _____ **Phone #:** _____

## Secondary Insurance Information:

**Insured Member's Name:** _____**SS#:** _____

**Insured's Employer:** _____ **DOB:** _____/_____/_____

**Insurance Carrier:** _____ **Plan Type:** _____

**Member or Medicaid ID#:** _____ **Group #**_____

**Insurance Mailing Address:** _____ **Phone #:** _____

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# Client Medical History

***Please describe the client's birth history. List any complications during pregnancy, birth or infancy.***

**How long was the pregnancy?** _____

**Was there any illness or accidents during pregnancy?** _____

**How long was the labor?** _____

**How long was the hospitalization after birth?** _____

**Describe any major accidents, surgeries, or hospitalizations:** _____

_____

**List any medical diagnoses (ADD, Autism, Dyslexia, Hearing/Vision Impairment, etc.) and age diagnosed?**

_____

_____

**List any allergies:** _____

**List any medications including the dosage, frequency and the condition that is being treated:** _____

_____

_____

**Are there any medications that you have to keep with the client such as an inhaler or EpiPen?** _____

**If yes, you are required to stay on site during each appointment. Please list the medications:** _____

_____

**List any specialized equipment such as braces, communication device, feeding tube, etc.:** _____

_____

**Describe any problems with vision?** _____

**Describe any problems hearing?** _____

## Please list the professionals that the client has seen along with the contact information:

**Psychologist/ Psychiatrist:** _____

**Neurologist:** _____

**Social Worker/ Educational Specialist:** _____

**Other:** _____

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# Client Social Information

**Have there been any recent, major changes? If yes, please explain:** _____

_____

**Is there any history of trauma, abuse, neglect, accident, etc? If yes, please explain:** _____

_____

**Does the client interact appropriately with others? If no, please explain:** _____

_____

**Does the client express emotions appropriately? If no, please explain:** _____

_____

**Does the client play appropriately? If no, please explain:** _____

_____

**Does the client play appropriately with others? If no, please explain:** _____

_____

**Does the client have any behavioral difficulties, for example aggression, anxiety, social problems, etc.:** _____

**If yes, please specify:** _____

_____

**What method of discipline is used at home, for example "time out"?** _____

_____

**What makes the client happy or unhappy?** _____

_____

**What toys, activities, hobbies, TV shows, characters does the client enjoy?**_____

_____

**What tips can you provide that would help us work with the client?**_____

_____

_____

_____

_____

_____

_____

_____

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# Client Developmental History

***Please indicate the client's age when they first began the following.***

| Physical Developmental Milestones | Age | Fine Motor Milestones | Age |
|---|---|---|---|
| Tolerated tummy time | | Grasped toy | |
| Rolled independently | | Pointed | |
| Sat independently | | Picked up small items | |
| Crawled | | Clapped | |
| Pulled to stand | | Waved | |
| Walked | | Stacked blocks | |
| Rode Tricycle | | Put shapes in sorter | |
| Runs | | Scribbled | |
| Jumped on 2 feet | | Colored | |
| Kicked a ball | | Removed top | |
| Caught a ball | | Cut paper | |
| Rode a bicycle independently | | Wrote name | |
| **Self-care Milestones** | **Age** | **Feeding / Oral Motor Milestones** | **Age** |
| Finger fed | | Drank from straw | |
| Used utensils to eat | | Drank from cup | |
| Undressed self | | Ate baby / soft foods | |
| Dressed self | | Ate table foods | |
| Potty trained | | Ate resistive foods | |
| Buttoned/ Zippered | | Brushed own teeth | |
| Tied Shoes | | Visited dentist | |
| **Social Milestones** | **Age** | **Emotional Milestones** | **Age** |
| Made eye contact | | Able to calm self | |
| Played peek a boo | | Smiled at people | |
| Understood "no" | | Laughed | |
| Babbled | | Anxious when away from caregiver | |
| Said first word | | Demonstrated independence | |
| Identified objects / pictures | | Expressed fear | |
| Followed simple directions | | Expressed anger / frustration | |
| Able to take turns / share | | Expressed pride | |
| Understand pretend play | | Remained calm during stressful event | |

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# Caregiver Concerns

***Please explain any concerns you have about the client under each heading below.***

## Developmental Delays

**Delayed walker**_____
**Delayed communication skills**_____
**Delayed motor skills development**_____
**Delayed interaction skills**_____

## Self-care / Daily Routine Difficulty

**Feeding**_____
**Grooming**_____
**Dressing**_____
**Clothes Fasteners**_____
**Writing**_____
**Fine Motor Skills**_____

## Feeding

**Picky Eater**_____
**Feeding Problems**_____
**Overstuffs**_____
**Gagging / Choking / Reflux**_____

## Gross Motor Skills

**Decreased Mobility**_____
**Falls Often**_____
**Decreased Strength / Endurance**_____
**Wears / Needs Braces**_____

## Sensory / Social / Emotional

**Meltdowns / Tantrums**_____
**Difficulty Transitioning**_____
**Anxiety / Frustration**_____
**Difficulty Interacting with Others**_____

## Communication

**Client has difficulty understanding words**_____
**Client has difficulty talking or communicating needs**_____
**Others have difficulty understanding the client**_____
**Talks too loud or too soft**_____
**Talks too fast or too slow**_____

## Any other concerns: _____

_____

_____

_____

_____

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# Consent for Treatment

**Client's Name:** _____

**Date of Birth:** _____ **OT4KIDS ID#**_____

**I consent to treatment/care as determined to be necessary, by health care providers practicing at this facility.**
I understand that treatment/care will include a variety of medical services based upon the nature of my condition.
I understand that this facility is an academic therapy clinic and my care team may include students or other trainees. Therapists and Assistants work collaboratively to provide services. I consent to the client being seen by either a SLP or SLPA as part of their speech therapy plan, a PT or PTA as part of their physical therapy plan, and an OTR or COTA as part of their occupational therapy plan. I am aware that the practice of medicine is not an exact science and I understand that no guarantees have been made to me about the results of treatments, examinations, or procedures. I am aware that agencies may be contracted to help to provide treatment/care at this facility. I consent to the use and disclosure of protected health information about me, including information, if any, regarding HIV status or AIDS, for treatment, payment and healthcare operations.

## Therapeutic Holding Policy

If a patient's behavior reaches a level that the therapist deems to be in some way physically harmful to themselves or others, the therapist may use measures to control, restrict or restrain the patient. The therapist will inform the caregiver as to the need and use of any such necessary measures. They must reach a mutual understanding of how therapy can proceed in a safe and productive way. If an agreement cannot be reached therapy may be discontinued.

**Does the client have an updated IEP?** ☐ **YES** ☐ **NO**

**Does the client have special precautions or allergies?** ☐ **YES** ☐ **NO**

**If yes, explain:** _____

**Legal Authority to sign for patient:** ◯ Healthcare agent ◯ Guardian ◯ Parent ◯ Administrator

**Printed Name**: _____

**Signature:** _____ **Date:** _____

**If you are signing this permission as the patient's guardian, healthcare agent, attorney in fact or the administrator/ executor of the patient's estate, you must provide appropriate documentation of legal authority before records may be released.**

**Patient is:** ◯ Minor ◯ Disabled

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**Consent verified by**: _____

# Authorization for the Release and Exchange of Healthcare Information

**I give permission for the exchange of information (verbal and/or written) regarding the client,**

_____ _____

**(Client's Name)** **(Date of Birth)**

**shared between OT4KIDS Inc. and,**

| **Primary Physician Name** (required): | **Primary Physician Clinic** (required): |
|---|---|
| | |

**Specialist(s):**

| |
|---|
| |

**School/Agency:**

| |
|---|
| |

| **Name:** | **Relationship:** | **Contact Information:** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

***The following people stated above are also authorized to pick up and drop off the client****

I understand that this information may be communicated through written, oral, or electronic means. Redisclosure of confidential information is prohibited without client consent. The information should be limited to include only that of the nature and to the extent which is specified here: medical and any other information pertinent and necessary to provide appropriate occupational, physical or speech therapy.

**Printed Name:** _____

**Signature:** _____ **Date:** _____

**Revocation of Consent:** You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use of disclosure that had already occurred prior to the date on which your revocation of consent is received will not be affected.

**Legal Authority to sign for patient:** ◯ Healthcare agent ◯ Guardian ◯ Parent ◯ Administrator

**If you are signing this permission as the patient's guardian, healthcare agent, attorney in fact or the administrator/ executor of the patient's estate, you must provide appropriate documentation of legal authority before records may be released.**

**Patient is:** ◯ Minor ◯ Disabled

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# Patient Privacy Policy & Procedure Statement

**Client's Name:** _____

**Date of Birth:** _____ **OT4KIDS ID #:** _____

OT4KIDS Inc. maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access and request a copy of your medical record and access history by signing a letter for release of your medical information. OT4KIDS Inc. will provide one (1) copy of your requested medical records at no charge, there may be fees associated with additional requests.

We protect all patient information within the guidelines provided by federal, state and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 336-236-6546.

OT4KIDS Inc. reserves the right to amend, change and/or revise our privacy policy at any time in accordance with federal, state and local rules, regulations and guidelines. Notice will be provided.

By signing the following document, you are indicating that you have read and fully understand OT4KIDS Inc. Privacy Policy. If you would like a copy of our full Privacy Policy for your personal records then please check the box below. This form shall be valid for one (1) year from date of signature below.

**Signature:** _____ **Date:** _____

**Legal Authority to sign for patient:** ◯ Healthcare agent ◯ Guardian ◯ Parent ◯ Administrator

**If you are signing this permission as the patient's guardian, healthcare agent, attorney in fact or the administrator/ executor of the patient's estate, you must provide appropriate documentation of legal authority before records may be released.**

**Patient is:** ◯ Minor ◯ Disabled

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# Attendance and Cancellation Policies

Our goal at OT4KIDS Inc. is to provide you and the client with convenient, accessible, high quality care. In order for us to assure convenience and accessibility to all of our patients, it is important that clients arrive in a timely manner for all scheduled appointments. If you have to cancel for any reason, you must cancel and rescheduled the appointment 24 hours in advance. This policy allows us to make better use of our available appointments for those patients in need of therapy.

**Scheduled Appointments**

To better provide for our clients we ask that you arrive five minutes prior to your appointment to accommodate for check-in time or the need to update or complete any information. We also ask you to be on time when dropping off & picking up, as this will allow us smooth transitions between appointments; being continuously late will result in the parent/guardian to remain at the facility for the duration of the appointment. We appreciate your help in these matters.

**Cancellation of an Appointment**

You may cancel your scheduled appointment by calling our office's during regular business hours.

- **Graham**: Monday-Thursday, 8:30-6:30
  Phone: 336-916-2106
- **Lexington**: Monday-Thursday, 7:30-6:30
  Phone: 336-236-6546

Appointments are in high demand and your early cancellation will give another client the opportunity to be seen by a provider.

**Missed Appointments**

A "missed appointment" is an occurrence where someone does not show up for an appointment and does not cancel the appointment in advance of the scheduled date and time. If you do not show up for your appointment and you do not cancel the appointment 24 hours in advance, we will record the missed appointment in the medical record as a "no call, no show". Each time you miss an appointment, you will be notified by telephone and you will be asked to reschedule. You must reschedule all missed appointments. If there are repeated missed appointments that are not rescheduled or 3 or more no call no shows in a month, it may result in the client being discharged from our facility.

**Schedule Changes**

Although we strive to meet your needs for requested schedule changes, we ask you to limit those only to permanent schedule changes. Reasons for permanent schedule changes would include a change in custody, a change in job status for the caregiver or a change in the client's school day hours. However, we are not able to accommodate schedule changes for sports and other extra-curricular activities or summer break. We understand at times, you will have other appointments that conflict with therapy such as a doctor's appointment or teacher conference; for those times, we will work with you to find a time to reschedule the client's therapy for that week.

**I acknowledge that I have read and understand the above policy statement regarding cancellations and missed appointments.**

**Signature:** _____ **Date:** _____

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# Financial Policy

Thank you for choosing us to provide therapy services. We are dedicated to providing the best possible evaluation and treatment for your child and regard your complete understanding of our financial policies as an essential element of your child's therapy. In order to reduce confusion and misunderstanding between our client's families and our company, we have adopted the following financial policy:

**Insurance**

- We accept assignment of insurance benefits once you schedule your first visit and we verify your benefit information prior to the visit. We require copayments, co-insurance deductibles and non-covered charges to be paid at the time of service. You can do this as you check in. Please be aware that some, and perhaps all, of the services provided may not be covered under your particular benefit plan. Any verbal verification of benefits or coverage is never a guarantee of payment. Therefore, we recommend that you get benefit information in writing from your insurance carrier in addition to us verifying your benefit information. **If your insurance company has not paid the services in full within 90 days, you will be notified and additional services may be discontinued.**
- It is imperative that you and our administrative office communicate prior to scheduling appointments as we will need to get a doctor's order and complete additional paperwork to aid in having your therapy visit covered.
- In the event that your insurance carrier determines a service to be "non-covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

**Medicaid**

- We will accept NC Medicaid and Healthchoice and any of the assigned Pre-paid Health Plans (Health Blue, Carolina Complete, Wellcare, UH Community Plan) for OT, PT and ST services upon receiving prior authorization from the Carolinas Center for Medical Excellence or the vendor for the assigned Prepaid Health Plan (PHP) for service. MEDICAID RECIPIENTS ARE REQUIRED TO MAINTAIN ACTIVE STATUS WITH MEDICAID OR A PHP
- Private insurance must be billed prior to accessing Medicaid funds. A current Medicaid or PHP card must be shared and kept on file at the clinic at the first visit.
- Unauthorized service or services not billable to Medicaid must be paid in full at the time of service.

**Private Pay Clients**

- Families who are private pay clients, due to no insurance coverage or large deductibles, will be required to pay for the evaluation and/or the initial therapy session in full at the time services are rendered.
- Financial agreements or payment plans can be arranged if the need arises, but if the terms are not met as agreed, the account will be deemed delinquent and collection action will be taken, after three (3) statements.

**All Patients**

- A valid insurance card must be on file in order for the service to be billed to your plan.
- A valid payment card must be placed on file prior to services being rendered. Please see attached authorization form
- Notification of any changes regarding your child's insurance coverage, Medicaid or other funds that affect reimbursement should be communicated to OT4KIDS Inc. within 24 hours of the change; otherwise, you may incur fees for service that are not covered because insurance verification and prior approval was not received.
- **Returned Checks:** A $25 fee will apply to all checks returned to our office as "unpaid". Payment for future services may be required by cash, credit card or cashier's check.

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- It is your responsibility to tell OT4KIDS Inc. within 24-hours if any of the above information changes for you or your child.
- Families will receive account information via mail, electronic mail (email) or via text to gain access to the payment portal

# Financial Policy

**Client's Name:** _____

**Date of Birth:** _____ **OT4KIDS ID#:** _____

I have read and fully understand the policies of this office regarding payments and insurance, as well as the cancellation/no show policies.

**Insurance Policy:**
I authorize direct payment of medical benefits to OT4KIDS Inc. The benefit referred to herein would be payable to me if I did not make an assignment and included major medical insurance. I understand that I am personally responsible to OT4KIDS Inc. for charges not covered or paid by this assignment. I am aware that in some instances, insurance may pay me for services rendered from OT4KIDS Inc. I agree to immediately forward all such payments to OT4KIDS Inc.

I agree to pay for services not covered by my insurance plan. I understand that I am responsible for following my insurance plan's regulations, policies and procedures.

**Signature:** _____**Date:** _____

**Legal Authority to sign for patient:**◯ Healthcare agent ◯Guardian ◯Parent ◯Administrator

**If you are signing this permission as the patient's guardian, healthcare agent, attorney in fact or the administrator/ executor of the patient's estate, you must provide appropriate documentation of legal authority before records may be released.**

**Patient is:** ◯Minor ◯Disabled

☐ **I would like a personal copy of OT4KIDS Inc. financial policy.**


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# Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

(Not required for Medicaid recipients)

Child's name:

Card Type: MasterCard / VISA / Discover / AMEX / Other:

Cardholder Name (as shown on card):

Card Number:

Expiration Date (mm/yy):

CVV code:

Cardholder ZIP Code (from credit card billing address):

I authorize OT4KIDS, Inc., to charge my credit card above for therapy services rendered. I understand that my information will be saved to file for future transactions on my account. I understand that the debit on my credit card bill will serve as my receipt.

Print: Date:

Signature: Date: