Pediatric Occupational Therapy Intake Form

---Family Information---

Child's name_______________________________________ Preferred Name _________________

Birthdate________________________ Male __ Female ___ Pro-noun (Optional) ______________

Address ____

Parent(s)/Legal Guardian(s) name ____

Main Contact(s) Phone Number __________________________/___________________________

Email____

With whom does the child reside? ____

Siblings/ages____

-----------------------------Primary Care Physician Information------------------------

Primary Care Physician Name: ____
Medical Practice Name: ____
Address: ____
Phone Number: __________________________ Fax Number: _____________________________

-----------------------------------Referring Information-----------------------------------

Referred by____
Reason for referral____

Child's strengths and interests____
____
____
____
____
____

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Caregiver concerns____
____
____
____
____
____

--**Medical History**--

Any difficulties during pregnancy? (diabetes, measles, toxemia, strep, drug/alcohol use, pre-eclampsia, depression, other) ____
____
____

Any difficulties during labor? (C-section, forceps, premature, low weight, NICU stay, other)
____
____
____

Chronic ear infections? Tubes placed? ____

Current prescribed medication____

Known food or other allergies____

Medical precautions____

Diagnoses given by other health care professionals__________________________________

Hospitalizations/surgeries/dates/length of stay____________________________________

____

Other health care services being received currently (Psychologist/therapist, PT, Speech, Nutritionist, Behavior Specialist, other) ____

____

Has your child received regular immunizations? ___________________________________

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--Developmental History----------------------------------

Please check all the milestones that your child has achieved:

__Rolling __sitting alone __crawling __pull to stand __walking __first word ___(age)

__finger feeding __eating with a spoon __cutting with scissors

Were milestones met within typical age ranges or delayed? ______________________________

--------------------------------------Daily Routines---

Please comment on your child's habits, oppositions, or your concerns for each item:

Sleep: (bedtime and routine, average hours slept, nap time/length, difficulties falling/staying asleep, difficulties waking) ____

____

____

Dressing: (dress/undress self, aversion to textures) _____________________________________

____

____

Toileting: (toilet trained/day and night) ____

Eating: (variety of food and textures) ____

____

Bathing/Oral Care: (independence, aversion, concerns) ___________________________________

____

Play and Social: ____

____

Classroom: (attention issues, academic concerns, IEP in place) ____________________________

____

____

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--------------------------------Behavior, Communication, and Motor -------------------------

Emotional concerns: (fears, anxiety, nightmares, poor self-esteem) ________________________
____
____

Behavioral concerns: (distractibility, impulsive, repetitive behaviors, tantrums, aggressive/destructive, nervous habits, defiant) ____
____
____
____

Do you have any motor development concerns? (walking up/down stairs, running smoothly, appears clumsy, stacking blocks, drawings, cutting, writing) ______________________________
____
____
____

Please briefly describe your child. (active, passive, curious, etc.) ___________________________
____
____
____
____

How does your child express him or herself? ____
____
____

Anything else to know about your child? ____
____
____
____
____

Any current or anticipated custody changes? (i.e. adoption, divorce, custody agreements?

____
____

CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Child

To be completed by Parent/Caregiver

Today's Date: ______________________________

Child's Name: ____ *Date of birth:* _______________________________

Your Name: ____ *Relationship to Child:* ___________________________

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance. *Please read the statements below. Count the number of statements that apply to your child and write the total number in the box provided.*

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box. ☐

Section 1. *At any point since your child was born...*

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box. ☐

Section 2. *At any point since your child was born...*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion

CYW ACE-Q Child (0-12 yo) © Center for Youth Wellness 2015

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Financial Policy and Fee Agreement

Please review our financial policy and fee agreement which describes our schedule of fees for service, policies regarding charges not covered by insurance, and additional fees. Please be sure that you understand the financial agreements regarding insurance reimbursement, methods of payment, and dues regarding cancelations, missed appointments, and past due accounts. If you have any questions or concerns about your individual policy and its coverage, please speak directly with your provider prior to signing this agreement.
Invoices are generally sent out weekly via email.
Payment is expected at time of service or within one week of received invoice.

Cost:
Evaluations - $160
55-minute treatment sessions - $135
30-minute treatment sessions (pre-approval required) - $75

Missed Appointments or Late Cancelation Policy:
Missed appointments or cancelations without a 24-hour notice may be assessed up to $75.
In addition, clients who accumulate excessive cancellations or missed appointments may lose preferred time slots and in extreme cases may be removed from the schedule.

Additional Fees:
Checks returned due to non-sufficient funds will be assessed a $20 fee
Past due accounts over 30 days may be assessed an extra $25 per month fee

Insurance Reimbursement:
Engage Therapy Center accepts and processes payments through a variety of insurance providers. Currently we work with Blue Cross Blue Shield, Anthem, Priority Health, and Cigna. Coverage is based on diagnosis, procedure codes, referring provider, and insurance plan. It is recommended that individuals contact their individual providers to fully understand their benefits, including deductibles, co-pays, exclusions, and allowed number of therapy visits. As insurance is a contract between you and your insurance company, Engage Therapy is not liable for gaps in coverage, lack of coverage or other insurance denials or disputes.

Obligation of payment is understood not to be dependent on the client receiving third party reimbursement from outside insurance coverage. We support and encourage our clients to pursue the maximum amount of financial reimbursement from third party payers, such as health insurance agencies. Ultimately, it is the client’s responsibility to submit and secure coverage that falls outside of Engage’s partnered insurance companies. Private pay documentation differs from standard documentation; therefore, it is necessary to alert your therapist before the evaluation if you will be pursuing third party reimbursement.

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Insurance Coverage and Billing:
I have read and accept Engage Therapy's financial policy and I agree to (1) allow Engage Therapy Center to bill my insurance directly for services provided; (2) give Engage Therapy Center permission to release information about me that the insurance company may require in order to process payment; (3) assist with the claims process as required by Engage Therapy Center or my insurance provider; (4) allow Engage Therapy Center to communicate billing information to the insurance holder.
I understand that if my insurance plan requires a deductible amount prior to coverage, I will be responsible for the full session fee until the required deductible amount has been met.
I understand that it is my responsibility to notify Engage Therapy Center if my insurance plan/coverage changes.

Insurance Information
Primary Insurance: ____
Insurance policy holder: ________________________DOB_____________________________
Relationship to client: ____

Address and contact information if different than client's primary residence:
Address: ____
City/State/Zip: ____
Phone: (H)______________________(W)___________________(C)____________________

Email address to send invoices to: ____

Patient Name (printed) ____

Patient/Guardian signature____

or

Private/Self-payment for Services

I have read and accept Engage Therapy's financial policy and I agree that I will self-pay for services at Engage Therapy Center. I agree to the fee schedule outlined in this document. I understand that payment for services is due at the time services are provided.

Patient Name (printed) ____

Patient/Guardian signature____

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Engage Therapy Center to use and disclose protected health information (PHI) to carry out treatment, payment and health care operations, and communicate to other health care providers and schools.

The Notice of Privacy Practices provided by Engage Therapy Center more fully describes such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this contract. I acknowledge that this release is voluntary and may be voided or edited at any time. I have the right to request that Engage Therapy Center restrict how it uses or discloses PHI.

With this consent, Engage Therapy Center may call my home or alternate location and leave a message regarding appointments or insurance/payment questions.

With this consent, Engage Therapy Center may mail any items that assist the plan of care, such as appointment reminders and patient statements, as long as they are marked "Personal and Confidential." Additionally, Engage Therapy Center may email me information, such as appointment reminders and patient statements.

By signing this consent, I give permission for Engage Therapy Center to communicate information about the treatment session with relatives and adults bringing my child to his/her appointment.
These individuals are not to receive information: ______________________________________
____

Client's name: ____ Date:______________________
Printed Name of Legal Guardian:____
Signature of Legal Guardian: ____

Specific providers I would like Engage Therapy Center to release information to if requested:

Name of provider: ____
Facility: ____ Phone: ________________________

Name of provider: ____
Facility: ____ Phone: ________________________

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Photography and Recording Consent

☐ I agree to photos/videos being taken for clinician use. They will be used for the purpose of evaluation, planning, and mentoring. The materials will only be viewed by Engage Therapy therapists and fieldwork students.

☐ I agree to photos/videos being used for promotional materials for Engage Therapy Center. This may include social media, flyers, or brochures. I will be shown materials for approval before publication.

Signature of Client or Legal Guardian: ____