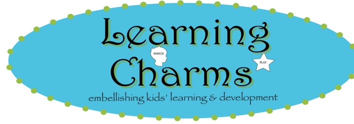

stephanie@learningcharms.com
DBA: Learning Charms
Go Your Own Way, Inc.
Mobile: 980-721-4839 Fax: 980-229-464
TIN: 26-4353232 2

Occupational Therapy Client Intake Form

Please return intake forms via email or fax as listed above

Today's Date: ______________________________

Child's Name: __________________________________ Parent(s) Name: ___________________________
Date of Birth: ____________________ Phone: _________________________________
Age: _______________________ Address: _______________________________
____

Parent Email Address:________________________________

Primary Physician: ____________________ Physician Group Name: _____________________
Diagnosis (if any): ____________________ Medications (if any): _______________________

Child lives with (check all that apply): Mother Father Brother(s) Sister(s) Grandparent(s) Guardian
Marital Status of Parent(s): Single Married Divorced Separated Widowed
Parent Name(s):____
Mother's Place of Employment: __________________ Mother's mobile: ___________________________
Father's Place of Employment: __________________ Father's mobile: ____________________________

Heath Insurance: Yes No
Health Insurance Company: ____________________________________

Who we may thank for referring your child to us? ____

Has child ever received occupational therapy? Yes No If yes, please state where and year: _____________________
Has child ever received speech therapy? Yes No If yes, please state where: _____________________

Developmental and Medical History:

1. Did water break more than 24 hours prior to delivery? Yes No
2. Develop toxemia/high blood pressure? Yes No
3. Complications during labor or delivery? Yes No
4. Mother's age at delivery: __________

Birth History:

1. Was child full term? Yes No Please list at how many weeks child was born: ________________
2. What was the child's weight? ______________
3. Was child born cesarean? Yes No
4. Was child born in breech position? Yes No
5. Did child require hospitalization? Yes No If yes, please describe: ___________________________

Child's Health:

1. Any known allergies? Yes No If yes, please describe: ___________________________________
2. Has child had an eye exam by a doctor in last year?_______________ if yes, by Dr. __________________
3. Does child wear glasses? (if yes, please state purpose)________________________________
4. Any diet restrictions? Yes No If yes, please explain: _____________________________________
5. Has child had chronic ear infections in the past? Yes No
6. Did child require PE (ear) tubes? Yes No
7. Has child had any broken bones?_______________________________________

8. Please list any medical or surgical procedures to date:
   ____
9. Has child ever sustained a serious fall, or ever lost consciousness? If yes, please explain:____
   ____

Developmental Milestones: **Age Able to Perform Without Help:**

insert age or if unknown use: "N" for normal, "L" for late, "E" for early

Started babbling	
First word spoken	
Started eating with fingers (finger foods)	
Fed self with spoon	
Drank from a sippy cup	
Rolled over	
Sat without help	
Crawled	
Walked	
Potty trained	
Rode a bike without training wheels	

Self Help Skills:

1. Does child put on underwear, shirt and pants without help? Yes No
2. Does child tie shoes without help? Yes No
3. Does child consistently align zipper without help? Yes No
4. Does child consistently button without help? Yes No
5. Does child eat without help? Yes No
6. Given supervision, does child bathe/shower without help? Yes No
7. Does child put on socks without help? Yes No

Education, school and social history:

1. Where does your child currently attend school? ______________________________
2. What grade? __________________
3. Does your child receive any special support during his/her day (e.g. resource, speech therapy, counseling, etc):
   Yes No If yes, please list: ____
4. Has your child received any formal educational testing? Yes No If so, what and when?
   ____
   ____
5. What extracurricular activities does your child participate?
   ____
6. In your opinion, what are your child's strengths?
   ____
   ____
   ____
7. What are your concerns about your child?
   ____
   ____
   ____
   ____
8. What have you been told by other professionals (doctors/teachers/etc) about your child's abilities and needs?
   ____
   ____
   ____

9. What do you hope your child will achieve by receiving services at Learning Charms?
____
____
____

Learning Charms Waiver
I understand that Learning Charms assumes no responsibility for injuries or illnesses which my child may sustain as a result of participation in any day camps, classes, individual tutoring, therapy, the use of any equipment, exercise, or other activities. I acknowledge that I assume the risk for any and all injury and illness which may result from participation in these. In consideration of the privilege of participating at Learning Charms, I hereby voluntarily release and discharge the Learning Charms and its agents, servants and employees, and contractors from any and all claims for injury, illness, death, loss or damage which may be suffered as a result of participation in these activities. A parent/responsible party must discuss with the Learning Charms director or therapist any special conditions or circumstances involving their child prior to registration. I agree to have a physician examine my child within a reasonable time prior to the start of the program/activity to determine my child is free of communicable disease and has not been exposed to such. I hereby give permission to the medical personnel selected by Learning Charms staff to order x-rays, routine tests, treatment, to release any records necessary for insurance purposes and to provide or arrange necessary related transportation for me/my child in the event of medical emergency. I understand that no accident/medical insurance is provided with this activity.

I have read, and agree with the waiver

________________________________ Date:______________
Parent Signature

____
Parent Printed Name

GUM:
If child enrolls in Occupational therapy is 4 years or older, we often offer one piece of gum while supervised and when participating in fine motor and/or handwriting skills. Gum often will keep a child's mouth and mind busy while performing "difficult" work. Gum is also seen as a reward for most kids. We typically have gum choices such as "Juicy Fruit" or "Extra". Since gum can be considered as candy, we would like your permission to or to not offer.

____________________ (signature)
My child can have a piece of gum during therapy

____________________ (signature)
I do not want my child to have gum during therapy

Permission to Photograph and Videotape (Optional): I give Learning Charms my permission to photograph and/or videotape my child to be used for therapeutic, educational and advertising purposes. The child's name, and other identifying personal or service information would not be used under any circumstance.

____
Client/Guardian Signature Date

Policies, Procedures, and Consent for Treatment:

Please read Notice of Privacy Practices Here:
http://www.learningcharms.com/fees--policies-forms.html
I have read the Policies and Procedures and Notice of Privacy Practices from Go Your Own Way, Inc., DBA: Learning Charms and agree to the terms therein, including but not limited to Consent for Treatment and Financial Agreement. This signed consent shall remain in effect until client or guardian fills out a new consent.

________________________ Date:____________
Parent or Guardian's Signature

____

Parent of Guardian's Printed Name

Service Fees (effective February 1st 2016)

Occupational Therapy Evaluation: $357.00
Parent or Teacher Conference : $100 / hour

Occupational Therapy 30 minutes: $ 58.00
Occupational Therapy 45 minutes: $87.00
Occupational Therapy 60 minutes: $116.00

On line handwriting Tutoring and on line classes will be offered via our website in Spring 2016. Prices as noted on website.

LEARNING CHARMS
Financial Policy and agreement
effective 2/1/2016

Thank you for choosing us as your specialty care provider. We are committed to quality evaluation and treatment. Please be aware that payment of your bill is considered part of your therapy. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

Payment
Payment in full is due at the time of service. We accept cash, checks, or Visa/MasterCard. An insurance card/must be shown at each visit in order for the service to be billed to your plan. Insurance will not be filed retroactively. Most of the times, a therapy invoice will be sent the day after therapy was provided. Full payment is expected prior to the next appointment. Failure to pay full balance of invoice will result in cancelation of therapy sessions.

Insurance
We may accept assignment of insurance benefits after your first visit. However, we do require copayments, deductibles, and non-covered charges to be paid at the time of services. 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. If your insurance company has not paid services in full within 30 days, the balance will automatically be billed to your account. Balances in excess of 30 days must be paid before additional services can be rendered.

Minor clients
Parents/guardians are responsible for payment. In the case of divorced parents, foster care parents, etc., the adult who arranges for services for the minor is responsible for payment. Go Your Own Way, Inc. (DBA: Learning Charms) is not responsible for billing or collecting from any other party. For unaccompanied minors, treatment will be denied unless charges have been pre-authorized to a Visa/ MasterCard, or payment by cash or check at the time of service has been verified.

Managed care Insurance Plans (AETNA and MEDICAID ONLY)
If we are a participating provider, all copays, deductibles and non-covered services are due at the time of service. Managed care plans are complex and most always require pre-authorization for services. If you participate in a Managed Care Insurance Plan, it is imperative that you and our business office communicate prior to scheduling appointments. In the event that your insurance coverage changes, Learning Charms must be notified prior to the effective date of the new policy. If Learning Charms is not notified before the effective date, refer to Insurance paragraph. In the event private insurance coverage changes, Learning Charms must be notified prior to the effective date of the new policy. If Learning Charms is not notified before the effective date, refer to Insurance paragraph.

Usual and customary rates
Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of an insurance company's determination of usual and customary rates.

Cancellation Policy
Sick children should not attend any Learning Charms service. If a child did not attend school due to illness, then should not attend therapy. If your child becomes ill, please call or email us ASAP to cancel the appointment. We appreciate as much notification as

possible. If you need to cancel appointment for reason other than illness, at least a 12 hour cancellation is required to avoid a cancellation fee. Repeated cancellations may result in either forfeiture of permanent appointment or termination of service. Failure to contact the office prior to appointment time will result in a no show fee equal to the full therapy amount.

Insurance Disclosure Agreement (for clients who are using insurance benefits AND who have either AETNA or MEDICAID):
I have discussed my insurance benefits with a member of Go Your Own Way, Inc.'s , DBA: Learning Charms' business staff . I understand the information was provided directly by my insurance carrier and that verification of coverage does not determine claim processing and is not a guarantee of payment.

I agree to the following:
1. Contact my insurance carrier to verify coverage and benefits.
2. Contact my insurance carrier in the event claims are not processed timely.
3. Pay all claims not paid in full by my insurance carrier within 30 days of the date of service.
4. Accept full financial responsibility for all deductibles,
copayments, non-covered services and services not billable to insurance.
This may include one or more of the following:
• Books or materials
• Services rendered without diagnosis
• Additional testing or treatment
• Travel time
• Phone consultation
• Parent or teacher conferences

Guarantor Name (for clients with Aetna or Medicaid ONLY): ________________________________
Guarantor Signature ______________________________
Date ___________________________

Self /Private Pay Customers: (this means you do not have Aetna or Medicaid)
I have discussed my insurance benefits with a member of Go Your Own Way, Inc.'s business and/or clinical
staff. I understand any information was provided directly by my insurance carrier and that verification of coverage does not determine claim processing. I agree to waive the use of any insurance coverage and pay Go Your Own Way, Inc. directly for any services rendered under this agreement. I understand that services rendered under this agreement will not be filed to my insurance carrier.
I have elected to self pay for all handwriting/ occupational therapy /classes or services provided by Go Your Own Way, Inc.

I am aware of my right to access insurance coverage and aware of the formal appeal process for denied services. I have elected not to file for coverage and/or appeal for coverage of these services. This Self-Pay Agreement applies only to the services listed above; another level of care requires a review of benefit eligibility and/or another signed Financial Agreement.
Self /Private Pay Customers (continued):

Guarantor Name __________________________________
Guarantor Signature____
Date ____________________________________

---

end of document