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Occupational Therapy Client Intake Form

Please return intake forms via email, address, or fax as listed above

Today's Date: _____

Child's Name: _____
Date of Birth: _____
Age: _____
Home Address: _____ State: _____ Zip: _____

Parent Names: _____
Main contact 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
Mother's Place of Employment: _____ Mother's mobile: _____
Father's Place of Employment: _____ Father's mobile: _____

Who we may thank for referring your child for occupational or speech therapy services?
_____

Has child ever received occupational therapy? ☐Yes ☐No If yes, please state where: _____
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 (age 5 +)? □Yes □No
3. Does child consistently align zipper without help (age 4+) ? □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/ class ? _____
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. Where will your child attend school next year and rising grade (if known):
   _____
6. What extracurricular activities does your child participate?
   _____
   _____
7. In your opinion, what are your child's strengths?
   _____

8. What are your concerns about your child?

9. What have you been told by other professionals (doctors/teachers/etc) about your child's abilities and needs?

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

Scheduling Availability:
Based on your child's schedule, what days (M-F) and time ranges are best for office based sessions:

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 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

_____
Parent Signature

_____
Parent Printed Name

Consent For Treatment, Release of Information, & Permission to use images

Client Name:_____

Request of Information Release: I authorize Learning Charms to **release** information about my child in writing or verbally to the following (i.e. physician, babysitter, specialist, teacher (name), school, etc):

_____
_____ _____
_____ _____

Information to be released:
____Individual session information (how a child did/homework for upcoming week)
O.T. Evaluation _____ Progress Reports _____
Treatment Plan _____
Discharge Summary _____ Visit Notes _____
Specific Information NOT to be released (if any): _____
_____

_____ **Date:_____**
Parent or guardian's signature

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. Names 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

Service Fees (effective June 1st 2018)

Occupational Therapy Evaluation: $360.00

Parent or Teacher Conference : $100 / hour

Occupational Therapy 30 minutes: $ 60.00

Occupational Therapy 45 minutes: $90.00

Occupational Therapy 60 minutes: $120.00

No shows are billed at the same rate as the service that was missed

LEARNING CHARMS Financial Policy and agreement effective 3/28/2018

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. Most of the times, a therapy invoice will be sent 2-5 business days 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.

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.

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.

Self /Private Pay Customers: (this means you do not have NC Medicaid)

We are only in network with NC Medicaid. If you have any other insurance coverage and receive services from Learning Charms, Go Your Own Way, Inc., then you are considered self and private pay. I understand that services rendered under this agreement will not be filed to my insurance carrier by Go Your Own Way, Inc. / DBA Learning Charms.
I have elected to self pay for all handwriting/ occupational therapy /classes or services provided by Go Your Own Way, Inc. I understand that I am responsible for paying the rates as indicated on "Service Fees" section.

_____Guarantor Name
_____Guarantor Signature
_____Date

end of document