335 NE 10TH AVE.
CRYSTAL RIVER, FL 34429
P: 352-795-5552
F: 352-795-7751

951 CANDELIGHT BLVD.
BROOKSVILLE, FL 34601
P: 352-345-8836
F: 352-631-5509

OT 4 KIDS

General Patient Information

Patient's Full Name: _____ Today's Date: _____
Preferred name or nickname if any: _____
Date of Birth: _____/_____/_____ Sex: ☐Male ☐Female
Home Address: _____
City _____ State: _____ Zip _____
Referring Physician: _____ Phone: _____
Primary Care Physician: _____ Phone: _____

Parent/Guardian Information

Mother/Guardian Name: _____ Date of Birth: _____/_____/_____
Cell Phone: _____ Work Phone: _____ Social Security #: _____
Email: _____
Home Address (if different than patient): _____
City _____ State: _____ Zip _____

Father/ Guardian Name: _____ Date of Birth: _____/_____/_____
Cell Phone: _____ Work Phone: _____ Social Security #: _____
Email: _____
Home Address (if different than patient): _____
City _____ State: _____ Zip _____

Insurance Information

Primary Insurance: _____
Policy or ID Number: _____ Group #: _____
Policyholder's Name: _____ Date of Birth: _____/_____/_____
Secondary Insurance: _____
Policy or ID Number: _____ Group #: _____
Policyholder's Name: _____ Date of Birth: _____/_____/_____

Availability

Check times available for therapy. When there is no school are times more flexible? YES NO
Comments: _____

TIME/DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
8:00 AM						
9:00 AM						
10:00 AM						
11:00 AM						
12:00 PM						
1:00 PM						
2:00 PM						
3:00 PM						
4:00 PM						
5:00 PM						
6:00 PM						

Additional family members / friends that we can discuss or release information to:
Name: _____ Relationship: _____
Phone Number: _____ Transport / Release child to: YES NO

OT4KIDS POLICY AGREEMENTS

Appointment Policy

Cancelations must be made 24 hours prior to the scheduled appointment. A $50.00 fee will be charged for cancellations made without prior notice. OT4kids understands that unforeseen circumstances arise (illness, emergency, etc.) and may waive the fee on a case-by-case basis. When I do not show for an appointment (no call, no show), make repeated changes, or repeatedly arrive late, OT4kids has the right to cancel that permanent appointment slot or discharge from services.
Initial here: _____

Therapy Session

Therapy sessions include working with the client; discussing goals, progress, and homework; preparing and cleaning up the treatment room; and documentation. Siblings or other children are not to be brought into the session unless arrangements are made. Siblings must not climb on/use equipment/swings unless supervised by my child's therapist. Siblings in the waiting room must be supervised. My phone number must be readily available to my therapist should I choose to leave the waiting room while my child is in session. If I choose to leave, I will return promptly at 5 minutes before the to p of the hour for pick-up.
Initial here: _____

Consent for Treatment

I, knowing that my child has a diagnosis requiring occupational therapy, voluntarily consent to such care deemed beneficial by the clinician's professional judgment for the afore mentioned child. I am aware that the practice of occupational therapy is not an exact science and I acknowledge that no guarantee has been made to me as to the effect of occupational therapy treatment for my child.
Initial here: _____

Therapist's Absence

In the event that my child's therapist is absent, OT4kids will make every effort to arrange for coverage with another therapist. I may not be notified. It is my responsibility to let the office know that I require notification of such changes.
Initial here: _____

Release for Appointment Reminders

I grant OT4kids permission to send me an appointment reminder via email, voice mail or text messages. Email and text messaging may contain patient or clinic information such as, but not limited to, patient first name and clinic location.
I understand that I am **required** to confirm appointment reminders in order to keep said appointment.
Initial here: _____

Authorization to Release Medical Information

I authorize OT4kids to obtain or release any medical information necessary to provide medical services to my child and/or to process insurance claims. I authorize OT4kids to release any of my medical information that is required for any health care related utilization review, quality assurance activities or other healthcare operations. I understand medical information to be disclosed may include history, evaluation reports, consultation reports, progress notes, and discharge summaries. I understand this consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Excluding revocation, this consent shall remain in effect as long as my child is a patient of OT4kids.
Initial here: _____

FINANCIAL POLICY

Assignment of Benefits/ Privacy Practices/Treatment Consent Assignment of Benefits

I authorize release of medical information necessary for billing purposes and assign the payment of medical benefits be made directly to OT4kids. I understand that I am responsible for any balance in excess of the benefits provided by my policy. I understand that by signing below and accepting treatment I agree to abide by these terms. I understand that it is my responsibility to be aware of insurance requirements and limitations of providers.
Initial here: _____

Medicaid, and any related Care Management Organization

If my child receives services through Medicaid, I must provide a Medicaid Card. Medicaid provides for a limited number of treatments per month. If I have given any other agency or school permission to bill Medicaid, or have received an evaluation within six months, it may affect OT4kids' ability to receive payment and could result in patient charges from treatment.

Self-Pay:

OT4kids will work with me to establish a reasonable payment plan and/or discount so that lack of insurance coverage does not prevent my child from receiving the needed therapy; however, I will be held accountable for your financial agreement.

Private Insurance:

OT4kids will file my private insurance for me if I provide all the required information at the time services are rendered and agree to grant assignment of benefits to OT4kids. OT4kids will make every effort to gain pre-certification where needed; however, it remains my responsibility to make sure the pre-certification has been approved. Some insurance companies have contracts that reduce, limit, or exclude payments to therapists who are not in network. It is my responsibility to know if my insurance has such contracts and with whom. I will receive a monthly statement of my balance. Any balances for charges that are not covered are my responsibility and I will be expected to continue making payments until the balance is paid in full. In the event my insurance company does not make payment within 45 days of our billing, I will be expected to begin payment on the account. All copays are due at the time of service.
Initial here: _____

I **MUST** NOTIFY THE OFFICE OF ANY INSURANCE CHANGES PRIOR TO THE NEXT APPOINTMENT AS OT4KIDS MAY NEED TO AQUIRE ADAQUATE AUTHORIZATION AND/OR RESPONSIBILITIES OF PARENT/GUARDIAN PAYMENTS. FAILURE TO DO SO WILL RESULT IN BEING RESPONSIBLE FOR PAYMENT DUE TO IMPROPER INFORMATION.
Initial here: _____

Collection Proceedings:

I hereby agree that if I fail to make monthly payments once notified of my balance, rebilling charges may be added to my bill for each monthly statement I fail to respond with a payment. If OT4kids deems it necessary to place my account with a collection agency, their collection fees may be added to my balance.
Initial here: _____

Current Fee Schedule

Evaluations: $300.00 / Full Sensory Integrative Evaluation and/or other equivalent test: $600.00
Treatment Session: $150.00 per hour
Interactive Metronome (IM): $20.00 per hour
Court Documents: First 25 pages ($1.00 per page) and $0.25 per additional page.
Court Appearances: $150.00 per hour payable by the parent/guardian of the patient.
Initial here: _____

Training and Educational Policy

OT4kids participates in clinical education programs with area colleges and universities to give students experience in clinical practice.
I hereby _____give consent /_____decline to give consent for students to observe my child's therapy sessions, including, where appropriate, provide direct treatment under my clinician's direct supervision.
Participation is voluntary and you are not required to sign this consent form in order to receive treatment.
Initial here: _____

Release of Photographic and Recorded Information

I hereby _____give consent /_____decline to give consent for OT4kids to photograph and/or video and audio record my child for formulating treatment plans and objectives and assisting in professional education, teaching, and data collection. The images and recordings may be shared with other patients for the foregoing purposes. Under no circumstances will the patient's personal identifying information be shared or disclosed. I further _____give consent /_____decline to give consent, on behalf of my child, that OT4kids may use such photography and recordings for marketing or promotional purposes in OT4kids web and print marketing and grants and assigns permission to copyright, use, reproduce, and publish the images and recordings, without compensation.
Initial here: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Payment means obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

In addition, your confidential information may be used to remind you of an appointment (by phone, text, email or mail) or provide you with information about treatment options or other health related services including release of information to friends and family members that are directly involved in the patient's care. However, we will only disclose medical information that these people need to know.
We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state, or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. Any other uses and disclosures will be made only with your written authorization.
You may revoke such authorization, in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.
If you have any questions or a request regarding your child's information, please contact our office at the phone and address below.
If you believe you or your child's privacy rights have been violated, you may file a written complaint with OT4kids and the Secretary of the Department of Health and Human Services at the address below.

OT4kids, Inc.
335 NE 10th Ave.
Crystal River, FL 34429
352-795-5552

Secretary of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

I hereby execute this document on the client's behalf. I have read and fully understand each part of this document. I represent and verify that I am authorized to execute this document on behalf of the client named above. I understand that I am entitled to receive a signed copy of this document. I acknowledge that I may change any of my elections at any time in writing.

Responsible Party Signature: _____
Relationship:_____ Date: _____
Responsible Party Printed Name: _____

MEDICAL EMERGENCY CONSENT

This is to authorize OT4kids, Inc. to authorize emergency treatment for my child, to arrange and obtain emergency treatment, and/or transportation to nearest medical facility and Emergency Physician on duty in the event that I cannot be located to give permission for treatment.

Child's name: _____

Date of birth: _____

Diagnoses: _____

Insurance: _____ Policy Number: _____

Known medication allergies:

_____

Important medical information for emergency staff to know: _____

_____

_____

Parent / Guardian Name: _____
Phone number: _____
Address: _____
_____

Alternate emergency contact:
Name: _____ Phone: _____
Relationship to patient: _____

Alternate emergency contact:
Name: _____ Phone: _____
Relationship to patient: _____

Responsible Party Signature: _____ Date: _____
Relationship: _____
Responsible Party Printed Name: _____