Occupational Therapy 2016-2017 Intake Packet

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11001 Hammerly Boulevard, Houston, Texas 77043
Call: 713-935-9088 **Fax:** 713-935-0654

Occupational Therapy Case History

Child's Information

Today's Date: ___________________________

Child's name: _________________________________ DOB: _____________ Age: ________ M/F: _________

Current Diagnosis: ____

Home Address: ____Home Phone: ___________________

School: ____Grade: ________________

Referral source (e.g., Doctor, Teacher, Parent): ____

Parent Information

Parent #1 name: __________________________________ Occupation: ______________________________

Home Phone: _____________________ Cell Phone: ____________________ Work Phone: ______________

Email: ____

Parent #2 name: _____________________________________ Occupation: ___________________________

Home Phone: _____________________ Cell Phone: ___________________ Work Phone: _______________

Email: ____

Emergency Contact: _____________________ Relationship: _______________ Phone: _________________

Child's Physician's Information

Child's Primary Physician: ____________________________ Phone: ___________________________

Date of your child's last Medical Checkup: ____

Is your child currently receiving OT services? If so where? _______________________________________

Signature required for OT prescription: ____

Please list other Healthcare Providers (e.g., Psychiatrist, Developmental Pediatrician, Physical Therapy, Play Therapy, Neuropsychologist):

Name: ______________________________Profession:____________________Phone:___________________

Date of last visit: ________________________

Name: ______________________________Profession:____________________Phone:___________________

Date of last visit: ________________________

Name: ______________________________Profession: ___________________Phone:___________________

Date of last visit: ________________________

Family History:

Please check if there is any known history of the following in the immediate or extended family?

Autism/PDD ____ ADHD _____ Learning Disabilities ____

Hearing Loss _____ Anxiety_____ Speech/Language Delays _____

Other: ____

Your Child's Personality

What are your child's interests at home? (e.g., sports, hobbies)

____

____

What does the child/teacher report your child's likes and dislikes to be at school?

____

____

What things about your child do you enjoy?

____

____

Describe how your child interacts with siblings or other children?

____

____

Describe the play activities that your child engages in.

____

____

Does your child play interactively with his peers?

____

____

Does your child play independently?

____

____

What are your primary areas of concern/ what are you hoping for the Occupational Therapist to address? (e.g., Academic, Sensory, Motor, Play, ADLs (eating, dressing)).

____
____
____

What are your goals for Occupational Therapy?

____
____
____

Please list any Medical Precautions/Allergies

____
____
____

Is your child receiving any other services at School (i.e. Speech, Physical Therapy, Special Education, Early Intervention)?
____

What (if any) special equipment does your child use?

Wheelchair: ______ Eye glasses: ______ Hearing Aids: ______ Braces/Orthotics: ______

Walker: ______ Communication Device: ______ Crutches: ______ Other: ____________________

Medications

List any medications that your child is currently taking and their purpose:

Medication: ___________________________________ Purpose: ____________________________

Medication: ___________________________________Purpose: _____________________________

Medication: ___________________________________ Purpose: _____________________________

Medication: ___________________________________Purpose: ______________________________

Comments:

____
____

Birth History:

Were there any difficulties before, during, or after birth? __No __Yes. If Yes, please specify below:

____
____

___Length of pregnancy: _________Birth was: ___Vaginal ___Cesarean (Planned/ Emergency) ___Breech

Please state reason for Cesarean birth: ____

Was child premature? ___Yes _____ No

Born at how many weeks gestation? ________

Birth Weight_______ Lb. ________oz.

How many days did mother stay at the hospital after birth? ____

How many days did child stay at the hospital after birth? ____

Check the following if they apply to your child:

___Vacuum Delivery ___Preeclampsia/Toxemia

___Gestational Diabetes ___IUGR (Intrauterine growth restriction

___feeding/latch ___Oxygen at Birth

___NICU stay: Duration: _______ ___Forceps Delivery

___Other:____

____

____

Childhood Illnesses/Problems

Please list significant illnesses, hospitalizations, etc.:

____

____

____

Please check any of the following if they apply to your child:

___Chronic ear infections ___Colic ___Tubes in ears

___Poor sleep ___Frequent antibiotic use ___Tonsils/Adenoid Surgery

___Asthma ___Frequent fevers ___Reflux

___Lyme Disease ___Compromised immune system ___Surgeries: list above

___Abnormal muscle tone (tension) ___Abnormal Lab results ___Poor weight gain

___Torticollis ___Cardiac Issues ___Measles

___ Mumps ___Pneumonia ___Chicken Pox

___Bronchitis ___Allergies ___Head Injuries

___Respiratory problems Other______________

Developmental Milestones: Fill in the blanks to describe your child to the best of your ability:

Rolled over at ___ months/years Sat at ___months/years Crawled at ___ months/years

Stood at ___months/years Walked at ___months/years Talked at ___months/years

Fed self ___months/years Dressed at ___months/years Toilet trained at ___months/years

If there was anything unusual you noticed in any of the above developmental milestones, please explain:

____

____

Activities of Daily Living (Routine Activities).

Circle the type of assistance that your child requires during the following tasks:

(*Set-up= parent only sets up materials for child)

	Independent	Set-Up	Verbal Assistance	Physical Assistance	Dependent
Putting Clothes on					
Taking Clothes off					
Putting Socks On					
Taking Socks Off					
Putting Shoes On					
Taking Shoes Off					
Fasteners (e.g., buttons, snaps, zippers)					
Grooming (e.g., bathing, brushing teeth, washing hands, brushing hair)					
Opening Containers					
Toileting					

Comments:

____

____

____

Feeding /Eating

Did your child have any feeding problems as an infant?

____

____

Was your child bottle fed or breast fed and for how long?

____

____

Do you have any concerns about your child's weight/growth?

____

____

Are you concerned about the amount and/or the variety of foods your child eats?

____

____

Does your child dislike particular textures of food? YES / NO

If yes, please explain:

____

____

Check below if your child had/has any of the following feeding difficulties:

Poor Suck______ Required a feeding tube______ Reflux/vomiting _______ Open cup ______

Swallowing ______ Difficulty chewing ______ Gag/choke often_______

Finger feeding_____ Spoon use______ Fork use ______

Please list any other feeding concerns you may have below:

____

____

Hearing/Vision

Has your child ever had a vision test? _____________

Date of last vision test: _______________

What were the results of that vision test____.

Has your child ever had a hearing test? ___________________________

Date of last hearing test: ______________

What were the results of that hearing test? ____.

Sensory Development

Is your child overly sensitive to sensory experiences (e.g., sounds in restaurants, textures, bright lights, smells)? If so, please explain:

____
____

Does your child take longer to react or doesn't react to sensory experiences (e.g., appears to be in his/her own world, does not respond to his/her name when called)? If so please describe.

____
____

Does your child seem to actively search or seek out sensory experiences (e.g., constant desire for pushing, pulling, and hanging off things; on the move constantly; seems unable to stop talking; touching people to the point of irritating others)? If so, please describe:

____
____

Does your child have a difficult time distinguishing sensory experiences? (e.g., trouble distinguishing objects in pockets, trouble recognizing objects by their shape, trouble differentiating smells). If so, please describe:

____
____

Does your child seem clumsy (trips/falls frequently) when executing movement, performing unfamiliar movements or completing tasks with multiple steps? If so, please describe

____
____

Does your child have poor balance during motor activities (e.g., biking, karate, and gymnastics)? If so, please describe

____
____

Does your child have difficulty sustaining adequate posture at a desk/table (slumps, leans on arm, head too close to work, props head on hands)? If so, please explain

____
____

OtherComments:____
____
____
____
____

Parent Signature ____ Date ________________

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

Child's Name (Print):____________________ Date of Birth:__________________________

Mother's Home #:______________________ Father's Home #:______________________
Mother's Work #:______________________ Father's Work #:______________________
Mother's Cell #:________________________ Father's Cell #:________________________

In the event that we cannot be reached to make arrangements for emergency medical attention, we authorize Karen Dickerson, Clinical Director, or a designated staff member to take my child to:

Doctor ____
Address ____
____
Phone # ____

Or to the nearest hospital, and we give our consent for any and all necessary treatment. In case of emergency treatment, please inform the medical staff that our child has the following allergies and that our child takes the following medication(s) on a daily basis (include dosage):

____

____

____

Please list two (2) persons whom we may contact in the event of any emergency:

__________________________________ _______________ ____________________
Name Phone Relationship

__________________________________ _______________ ____________________
Name Phone Relationship

____ _________________________________
Mother's signature Father's signature

____ _________________________________
Child's Name & Birth date (please print) Date of signatures

THIS FORM MUST BE KEPT UPDATED AT ALL TIMES.

Consent for Treatment

Client: ____ Date of Birth: ___________________________________

Parent/Guardian: _______________________________ Relationship to Client:_____________________________

I,____ , hereby give consent for the above named child and/or myself to receive services at the Carruth Center of The Parish School. This consent is given until I give notice that these services are no longer requested or until Carruth Center of The Parish School professionals notify me these services will no longer be provided. I certify that I have legal responsibility for this child and am authorized to seek and consent treatment for him/her. I understand that all information provided to Carruth Center of The Parish School professionals is confidential and will generally be released to others only with my written consent. I understand that Carruth Center of The Parish School professionals are required to disclose confidential information without my consent in certain circumstances which includes, but is not limited to, 1) if is determined there is a probability of imminent physical injury by my child to himself/herself or other(s), or if there is a probability of immediate mental or emotional injury to my child 2) if the disclosure is required or authorized by law, legal proceedings, or court order 3) to qualified individuals, corporations, or governmental agencies involved in paying or collecting fees for mental or emotional health services for my child 4) to other professionals and personnel, under the direction of Carruth Center of Parish School professionals providing services to my child, who participate in the diagnosis, evaluation, or treatment of my child 5) a judicial or administrative proceeding brought against Carruth Center of The Parish School professionals by myself or my child 6) in the event it is believed my child is the victim of physical abuse, sexual abuse, or neglect, or if my child divulges information about the physical abuse, sexual abuse, or neglect of a child, elder, or disabled person.

The professionals rendering services through Carruth Center of The Parish School are dedicated to using established and empirically supported psychological, behavioral, and educational evaluation and intervention procedures to optimize the social, emotional, and cognitive development of each child. In the event a child presents as an immediate danger to himself/herself, others, or property, the least restrictive intervention shall be utilized to provide safety for the child, others, or property. While verbal mediation will be the primary intervention utilized, at times physical contact may be required to provide safety for the child, others, or property. At these times, a "therapeutic hold" will be used to help manage a child's behavior until verbal mediation can effectively be used to address the situation and/or until the child no longer presents as an immediate danger to himself/herself, others, or property.

My signature on this document indicates I have read the above information and have a clear understanding of the procedures, policies, and therapeutic interventions described. I have been given the opportunity to have my questions answered regarding the above-described information. I understand that I have the right to withdraw treatment for my child at any time.

_______________________________________ _____________________________

Signature of Parent/Guardian Date

_______________________________________ _____________________________

Witness Date

PAYMENT CONTRACT & AUTHORIZATION
Occupational Therapy

Client's (Childs) Name: ______________________________________

The fees for Occupational Therapy sessions are invoiced on or around the **5th** day of the month following the last session of the previous month. Payment for these sessions will be direct debited from your account or charged to your credit card on or around the **15th** day of the following month (or the next business day), depending on the selection below and payment authorization information provided.

Occupational Therapy Evaluation with a report is $350.00.

Individual Occupational Therapy is $130.00 per hour session

_______ Please charge my **credit card** (complete the credit card authorization on following page).

_______ Please **direct debit** my account (complete the ACH direct debit on following page).

In consideration for the acceptance and enrollment of _______________________ in individual treatment, or group program, I (we) the undersigned parent(s), and/or guardian, or other endorser hereof, promise to pay to the order of Carruth Center, Inc. all applicable fees charged for services rendered due on/or before the fifteenth of the month following treatment. Outstanding balances may result in suspension of services until total account balance has been cleared. There will be a $20.00 service charge for NSF checks.

_______I understand that the form or payment on file must be kept current. To update your form of payment on file, submit a new "Payment Contract & Payment Authorization" form to the Carruth Center, Inc. Business Office before the 15th of the month.

_______I authorize the Carruth Center, Inc. to charge the agreed upon credit card or ACH debit on or around the 15th of each month for services provided during the previous months (generally on going individual services) OR on the dates specified in the payment option selected on the signed contract for services (generally group therapy).

_______I agree that if initial payment processing is declined for any reason, Carruth Center, Inc. may continue to process the payment against the card on a regular basis, until the payment is successfully processed and the balance is resolved. Reoccurring payment declines will result in payments being due at the time of service. In this circumstance acceptable form of payment would be exact cash or a credit card that can be successfully processed at the time of service.

_______I acknowledge and understand the cancellation, late arrival, and late pick-up policies. See Carruth Center Policies form.

See reverse side for payment authorization form
Carruth Center, Inc. must have a current form of payment on file for all clients.

THE CARRUTH CENTER
AT THE PARISH SCHOOL

PAYMENT CONTRACT & AUTHORIZATION

Client's (Childs) Name: ____

Credit Card Authorization

_____ Visa _____ MasterCard _____ American Express _____ Discover

Credit Card Number: ____

Expiration Date: ____________ Card Security Code (CSC): _________

Name on Card: ____

Address: ____

____

ZIP Code: ____

Phone Number: ____

ACH Direct Debit Authorization

_____ Checking Account _____ Savings Account

Depository Name ___________________________________ Branch _____________

City _______________________________ State ____________ Zip ______________

Routing Number ______________________ Account Number _________________

_______I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. Law.

Attach a blank voided check

This Authorization is to remain in full force and effect until Carruth Center, Inc. has received written notification from me (I or either of us) of its termination in such time and in such manner as to afford Carruth Center, Inc. and DEPOSITORY a reasonable opportunity to act on it.

Print Name: ____

Date: ____________________ Signature: _____________________________________

Carruth Center Policies

Client's (Childs) Name: ____

Please read carefully. **Both parents or guardians** are required to initial each line.

___ ___ **Clinic Visitation Policy:**

- Children must be accompanied by an adult in the lobby at all times.
- Please check in with Carruth Center, Inc. office before entering the therapy area. All parents and visitors must wear a visitor badge while in the Carruth Center, Inc. therapy area.
- Group observations must be scheduled through the Carruth Center, Inc. business office at least 24 hours in advance.

___ ___ **Cancellation Policy:**

The undersigned hereby acknowledges that failure to cancel a scheduled treatment session or a parent conference 24 hours in advance of the scheduled appointment will result in a 100% charge for the allocated session fee. Carruth Center, Inc. administration reserves the right to dismiss a client from therapy for inconsistent attendance. In addition, the undersigned hereby acknowledges that Carruth Center, Inc. reserves the right to withhold all test results and reports when professional fees are not paid as per above.

- **No show/no call cancellation**: The undersigned hereby acknowledges that failure to notify the treating clinician to cancel a scheduled treatment session will be considered a no show/no call appointment. We ask that all cancellations, not due to illness or a family emergency be made 24 hours in advance.
  A no show/no call appointment will result in a 100% charge for the allocated session fee.
- **Late Cancellation**: The undersigned hereby acknowledges that any cancellation, not due to illness or family emergency, that is made **<u>less</u>** than 24 hours in advance is considered a late cancellation. A late cancellation will result in a 100% charge for the allocated session fee.

___ ___ **Late Pick-up Policy:**

The undersigned hereby acknowledges that parents are expected to be in the Carruth Center, Inc. lobby or front porch area prior to the end of their child's therapy session. Carruth Center, Inc. late-pick up policy is as follows:

- Client families will be given 2 "passes" (no charge assessed) per fiscal year (August 1st - July 31st) for unexpected tardies not to exceed 5 minutes.
- Late pick-ups **BEYOND** 5 minutes **OR** post 2 "passes" will be charged per the quarter-hour at the standard individual therapy rate.
- Chronic tardiness may lead to parent being required to remain present on campus throughout therapy session.

Breakdown of Late Fees according to therapy discipline

Standard Speech, OT, Music Individual Therapy Sessions	Standard Individual Therapy Rate ($130.00)	Standard Mental Health Individual Therapy Sessions	Standard Mental Health Individual Therapy Rate ($140.00)
5-15 minutes	$32.50	5-15 minutes	$35.00
15-30 minutes	$65.00	15-30 minutes	$70.00
31-45 minutes	$97.50	31-45 minutes	$105.00
46 – 60 minutes	$130.00	46 – 60 minutes	$140.00

*standard mental health therapy hour is 45 minutes for children, and 50 minutes for adults)

- Late fees will be included in the monthly invoice. Failure to resolve fees with regularly scheduled, monthly payment processing, on or around the 15th of every month, will result in suspension of client services.
- Late pick up fees are not eligible for insurance reimbursement.

___ ___ **Late Start Policy:**

The undersigned hereby acknowledges that late arrivals will not be accommodated by extension of therapy time. Full session fee will apply to late arrivals. For example: If a client is 5 minutes late to their scheduled appointment time, the result will be a 30-minute session fee, even though it was only a 25-minute therapy session.

- Clients are encouraged to arrive to the Carruth Center, Inc. lobby 2 to 5 minutes prior to their scheduled session time.

___ ___ **Policy on Insurance:**

- Carruth Center, Inc. is a fee-for-service facility and families are responsible for all payments.
- Carruth Center, Inc. does not guarantee coverage and/or the ability to gain coverage of services. Coverage is determined by your individual policy.
- Carruth Center, Inc. is considered out-of-network, and therefore, we ask that families act as the liaison for any direct communication with their insurance companies.
- Carruth Center, Inc. does not submit claims on behalf of the client.
- Carruth Center, Inc. provides invoices and or services provided forms with necessary codes, clinician information, and clinic information for your convenience and ease of filing claims.
- Carruth Center, Inc. does not accept payment from insurance companies. All insurance checks issued to the Carruth Center, Inc. are returned to the insurance company with a request to issue payment to the insured. The insured is then notified by letter and copy of the check for their records.

Parent Name (Print): ______________________________ Date: __________

Signature: ______________________________

Parent Name (Print): ______________________________ Date: __________

Signature: ______________________________

AUTHORIZATION FOR REQUEST/RELEASE OF INFORMATION

Child's Name: ____

I hereby authorize:

Randi Raizner, PhD. _____ initial to consent
Carruth Center, Inc. _____ initial to consent
The Parish School _____ initial to consent

I hereby give permission to The Carruth Center for the following:

_____ In order to process a claim for benefits, I authorize the Carruth Center, to release to my insurance carrier any information regarding my child's medical history, symptoms, treatment, examination results, or diagnosis. Termination of consent must be submitted in writing.

Occupational Therapy REQUIRES Physician's name: ____

Below are listed the person(s), agencies and schools that the assigned individuals or company may contact:

Name Address Telephone # Fax #

1. ____
2. ____
3. ____

I understand any information obtained is strictly confidential and privileged.

_________________________ ____
Date Parent or Legal Guardian

A copy of this instrument is as valid as the original.

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Occupational Therapy
Schedule of Fees

- Occupational Therapy Consultation (60 minutes *without* a report) — $100.00
- Occupational Therapy Consultation (60 minutes *with* a report) — $130.00
- Occupational Therapy Evaluation (up to 2 hours *with* a report) — $350.00
- Individual Session (30 minutes) — $ 65.00
- Individual Session (45 minutes) — $ 97.50
- Individual Session (60 minutes) — $130.00
- Group Session (per hour) — $ 80.00
- Parent Conference (30 minutes) — $ 65.00