300 Redland Ct, Suite 100
Owings Mill, Maryland 21117

Phone: 410-653-3161
Fax: 410-653-3261

Intake Form

Date: _____ Appointment Time: _____

Patient Information

Child's Name: _____

Date of Birth: _____ Sex: Male / Female

Address: _____

City: _____ State: _____ Zipcode: _____

Medications: _____

Allergies: _____

Primary Care Physician: _____

Referral Source: _____

School and Grade: _____

Contact Numbers and Email Addresses

Parent's Name: _____Email: _____

Parent's Contact Number: (H) _____ (C) _____

Parent's Name: _____Email: _____

Parent's Contact Number: (H) _____ (C) _____

Emergency Contact

Name: _____Relationship to Child: _____ Contact Number: _____

Health Care Provider Information

My child is treated by the following health care providers:
(Check all that apply and include name and contact information)

___Pediatrician: _____

___Developmental Pediatrician: _____

___Psychologist or Psychiatrist: _____

___Neurologist: _____

___Occupational Therapist: _____

___Speech/Language Therapist: _____

___Physical Therapist: _____

___Behavior Specialist: _____

___Other (please specify): _____

Insurance Information

Insurance Company: _____

Insurance Company Phone Number: _____

Subscriber ID Number: _____ Group Number: _____

Subscriber's Name and Date of Birth: _____

Subscriber's Employer: _____

Relationship of Subscriber to Patient: _____

Insurance Benefits

Occupational Therapy Benefits: yes / no

Deductible: yes / no Amount of Deductible: _____ Amount Met: _____

Co-pay: _____ Co-insurance: _____

Referral: yes / no Authorization: yes / no Prescription: yes / no Treatment Plan: yes / no

Rehabilitative Benefits: _____

Habilitative Benefits: _____

Additional Information: _____

About Kids Occupational Therapy, LLC
300 Redland Ct, Suite 100
Owings Mills, MD 21117
410-653-3161

NOTICE OF PRIVACY PRACTICES

September 6, 2013

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how I may use or disclose your child's protected health information, with whom that information may be shared, and the safeguards I have in place to protect it. This notice also describes your rights to access and or refuse the release of specific information outside of this system except when the release is required or authorized by law or regulations.

Acknowledge of Receipt of this Notice

You will be asked to provide a signed acknowledgment of receipt of this notice. The intent is to make you aware of the possible uses and disclosures of your child's protected health information and your privacy rights. The delivery of your child's health care services will in no way be conditioned upon your acknowledgment.

Who Will Follow this Notice

This notice applies to all therapy services provided by About Kids Occupational Therapy, LLC. It also applies to office personnel and billing personnel.

Our Responsibility Regarding Protected Health Information

Your child's **Protected Health Information** or **PHI** is individually identifiable health information. This includes demographics such as age, address, email address, and relates to your child's past, present, or future physical or mental health or condition and related health care services. We are required by law to do the following:

- Make sure that your child's PHI is kept private
- Give you this notice of our legal duties and privacy practices related to the use and disclosures of your child's PHI
- Follow the terms of the notice currently in effect
- Communicate any changes in the notice to you

We reserve the right to change this notice. Its effective date is at the top of the first page and at the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about your child as well as any information received in the future. You may obtain a Notice of Privacy Practices by calling the phone number at the top of this notice.

Our System

About Kids Occupational Therapy, LLC works with several agencies and referral sources. Your child's health information will be shared in the following manner:

- Treatment – We will use and disclose your child's PHI to provide, coordinate, or manage your child's health care and any related services. This includes disclosure to your physician or other health care providers who becomes involved in your child's care.
- Within the office for administrative activities, quality assessment, oversight and peer review
- With our billing personnel and as necessary to obtain payment for your health care services
- With your insurance company or other payers as required for payment
- With the referring agency and case manager, if applicable
- With any other provider, school or agency with your written request. You may request written or verbal information sharing in writing. Your request should include a specified period of time for information sharing.

Required by Law

I may use or disclose your child's PHI if the law or regulation requires the use or disclosure. I will notify the appropriate government authority if I believe a patient has been the victim of abuse, neglect, or domestic violence.

Health Oversight

I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Legal Proceedings

I may disclose PHI during any judicial or administrative proceedings, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Parental Access

I may disclose your child's PHI to parents, guardians and persons acting in similar legal status.

Uses and Disclosures of Protected Health Information Requiring Your Permission

In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your child's PHI. Please notify your therapist if you do not want your child's PHI information to be discussed during the session.

Your Rights Regarding Your Child's Health Information

You may exercise the following rights by submitting a written request to About Kids Occupational Therapy, LLC.

1. You may inspect and obtain a copy of your child's PHI that is kept as a part of medical and billing records.
2. You may ask us not to use or disclose any part of your child's health information for treatment, payment, or health care operations. Your request must be made in writing. This request will be honored if we mutually agree that the restriction will not harm your child.
3. You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.
4. If you believe that the information we have about your child is incorrect or incomplete, you may request an amendment to your child's PHI as long as we are responsible for and maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment.
5. You may request that we provide you with an accounting of the disclosures we have made of your child's PHI. This right applies to disclosures made for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. This disclosure must have been made after September 6, 2013, and no more than six years from the date of request. This right excludes disclosures made to you or authorized by you, to family members or friends involved in your child's care, or for notification. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this notice.

Federal Privacy Laws

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). There are several other privacy laws that also apply including the Freedom of Information Act and the Privacy Act. These laws have been taken into consideration in developing policies and this notice of how I will use and disclose your child's health information.

Complaints

If you believe these privacy rights have been violated, you may file a written complaint with the Department of Health and Human Services. No retaliation will occur against you for filing a complaint.

This notice is effective in its entirety as of September 6, 2013.

Consent for Treatment

I hereby give my consent for *About Kids Occupational Therapy, LLC* to provide any necessary examination procedures and/or treatment for my child.

Parent or Legal Guardian signature: _____Date: _____

Release of Information/Assignment of Benefit

I hereby authorize the release of any medical or other information necessary to process claims. I also request payments of all benefits, including private insurance and third party payers, to *About Kids Occupational Therapy, LLC* for services provided and claimed.

Parent or Legal Guardian signature: _____Date: _____

Notice of Privacy Practices

I have been given a copy of *About Kids Occupational Therapy, LLC's* Notice of Privacy Practices, will review it, and keep it on file.

Parent or Legal Guardian signature: _____Date: _____

Payment, Cancellation, and Facility Policies

Billing Policy

As a courtesy to you, *About Kids Occupational Therapy, LLC* will bill your insurance carrier. However, it is the patient's responsibility to know his/her benefits. The patient is responsible for all charges described as patient liability, as well as any denied amounts. It is the responsibility of the patient to notify us of any changes made to your policy. Failure to do so will result in denials and the policy holder will be billed all fees. Co-pays or fees for service are due at the time services are rendered. Please promptly remit any insurance payments made directly to you for services billed by *About Kids Occupational Therapy, LLC*. You agree and understand that you are responsible for all costs of collecting monies owed if you fail to make any payments for which you are responsible.

Co-Payments, Co-Insurance, and Deductibles

Co-pays are due at the time services are rendered. If you have a deductible or co-insurance you will receive an electronic bill once we receive the Explanation of Benefits (EOB). These payments are due prior to your child's next therapy session. Payments can be made by Visa, Mastercard, Discover, Cash, or Check. A $35 fee will be applied for all returned checks.

Private Pay

The private pay fee is $135 per 45 minute session and $90 per 30 minute session. Payments are due at the time services are rendered.

Cancellation/No-Show Policy

Occupational therapy services often occur weekly for a duration of time. We understand that emergencies and illnesses happen, and your child may be unable to attend their weekly appointment(s). With the exception of emergencies and sudden illness, we require a **24-hour notice** for all canceled appointments. All cancellations must be emailed or text messaged to your therapist. Failure to provide 24-hour notice to *About Kids Occupational Therapy, LLC* will result in a **$30 cancellation fee**. The payment is due prior to your child's next appointment.

***In the event that you do not show up for your scheduled appointment and have not given any notice, a* $50 NO-SHOW fee *will be implemented*.**

Please be aware that we cannot bill your insurance company for these fees. Thank you for your cooperation in following this policy.

Inclement Weather Policy

In the event of inclement weather, please contact your therapist to discuss if your session needs to be canceled or rescheduled to an alternate day or time. Late cancellation fees may be waived.

Therapy Session/Treatment Room Policy

About Kids Occupational Therapy, LLC's mission is to provide your child a safe treatment environment when he/she arrives, receives treatment, and departs our facility. To this end, we request that only parents or legal guardians drop off, pick up or attend their child's session. Parents and legal guardians are to enter the facility when dropping off and picking up their child so that the therapist is advised of the child's safe arrival and departure. Parents can fill out a *Child Pick-Up Authorization Form* to allow individuals other than the parent or legal guardian to pick up and drop off their child for therapy sessions. If someone other than a listed authorized individual must pick up your child, the parent or legal guardian must give written notice to the therapist prior to the session.

Due to liability issues, siblings and/or other children are not allowed into the treatment rooms. Treatment rooms are for therapists and patients only. However, parents can request to be present during their child's treatment session. Thank you for allowing us to continue to provide the best quality of care for your child.

I have read and agree to the above policies.

Parent or Legal Guardian signature: _____Date: _____

Debit/Credit Card Authorization Form

I _____ authorize About Kids Occupational Therapy, LLC to keep my signature on file and to charge my card any fees for therapy services (co-pays, deductibles, etc), in addition to late cancellation and no-show fees. I understand that this form is valid for the duration of treatment unless I cancel the authorization in writing. I agree not to dispute charges ("charge back") for sessions that I have received or that I have not cancelled 24 hours prior to a scheduled session. I further authorize About Kids Occupational Therapy, LLC to disclose information about my attendance/cancellation to my credit card issuer if I dispute a charge.

Client Name _____

Cardholder Name _____

Cardholder Billing Address City_____ State_____Zip_____

Card Type (Visa/ MC/ Amex/Discover, HSA, FSA)_____

Account Number _____Expiration Date _____Security Code_____

Cardholder Signature and Date _____

Child Pick-Up Authorization Form

I hereby give authorization to the individuals listed on this form to pick-up or drop-off my child from therapy sessions at *About Kids Occupational Therapy, LLC.* Persons not listed on this form do not have permission to pick up or drop off my child.

Parent/Legal Guardian Signature: _____ Date:_____

1. Name: _____ Contact Number: _____
2. Name: _____ Contact Number: _____
3. Name: _____ Contact Number: _____
4. Name: _____ Contact Number: _____
5. Name: _____ Contact Number: _____

Patient Questionnaire

To help us gain a better understanding of your child's needs, please check off all that apply and describe below in the comment section:

Motor Coordination

__ Child's muscle tone appears "floppy" or too stiff

__ Poor posture during writing tasks/seated tasks

__ Poor balance or decreased spatial awareness (may bump into other people or things, difficulty walking in hallways or standing in line)

__ Appears clumsy or awkward during gross motor tasks (i.e. at recess or PE)

__ Poor motor planning (initiating, planning, and carrying out a task)

__ Decreased strength and/or endurance during motor tasks (may fatigue easily)

__ Difficulty crossing over the body's midline during fine and gross motor tasks

__ Avoids playing on the playground or participating in team sports

__ Poor sense of rhythm or balance

__ Has trouble learning new movement activities

Comments:

Fine Motor and Visual/Perceptual Motor

__ Difficulty manipulating small objects

__ No definite hand dominance during writing tasks

__ Poor or awkward pencil grasp or pushes too hard when writing

__ Difficulty grasping objects of different sizes

__ Difficulty grasping and using scissors

__ Difficulty copying simple lines and shapes

__ Difficulty with letter formation

__ Difficulty with letter size, alignment, and/or spacing

__ Difficulty completing puzzles or constructing objects

__ Difficulty with letter/shape recognition, color recognition, visual memory, letter reversals, etc.

__ Avoids or become easily frustrated with writing or fine motor tasks

__ Difficulty with fasteners or shoe tying (if age appropriate)

__ Difficulty with self-help skills (i.e. dressing, bathing/hygiene, feeding)

__ Difficulty managing belongings (i.e. backpack, school supplies, etc.)

Comments:

Sensorimotor Processing

__ Overly sensitive to sounds or easily distracted by noises

__ Overly sensitive to visual stimuli

__ Overly sensitive to tactile input or how certain things feel against his/her skin (i.e. clothing, tags, getting hands messy or dirty)

__ Picky eater with limited diet and/or negative reactions to certain tastes or textures

__ Constantly fidgets and/or touches/grabs things

__ Has difficulty sitting still

__ Difficulty listening and following directions

__ Decreased attention span

__ Inability to regulate activity level

__ Appears to need constant movement and is always “on the go”

__ Avoids movement activities or is fearful of having his/her feet off the ground

__ Enjoys crashing and falling with no awareness of safety issues

__ Difficulty maintain boundaries/personal space

__ Appears disorganized in space or has poor organizational skills

Comments:

Social/Emotional

__ Flat affect or low mood

__ Anxiety or separation issues

__ Clingy/whiny behaviors

__ Sleeping or eating problems

__ Difficulty tolerating changes in routine or transitions

__ Anger or irritability, may have frequent “meltdowns”

__ Extreme oppositional behavior

__ Talks too much or dominates the conversation

__ Does not listen carefully to the conversation and makes comments off-topic

__ Does not really understand or has trouble following the conversation

__ Makes inappropriate comments or interrupts others when they are speaking

__ Poor eye contact or body language

__ Difficulty sharing and/or taking turns

Comments:

If there is any additional information that you feel is relevant to the evaluation and/or treatment of your child, please describe below: