THRIVING KIDS THERAPY, LLC

CLIENT INFORMATION FORM

(Please Print)

Today's Date:	Your relationship to child:

PERSONAL INFORMATION

Parent/Guardian Last name: First: MI: DL#:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your first time in Occupational Therapy? ❑ Yes ❑ No	Child's Full Name:	Child's DOB: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home phone no.:	Cell phone no.: ( )

E-mail:	City:	State:	ZIP Code:

Pediatrician:	Pediatrician Address:	Pediatrician phone no.: ( )

Referred to clinic by (please check one box): ❑ Dr. _____ ❑ School ❑ Hospital

❑ Psychologist ❑ Family/Friend ❑ Google ❑ Website ❑ Business Card ❑ Other

Diagnosis (if applicable): Allergies: Medications:

SCHOOL INFORMATION (IF APPLICABLE)

Name of Child's School:	Teacher's Name:	School Address (or location receiving services):	School phone no.: ( )

Does your child receive Occupational Therapy at school? ❑ Yes ❑ No If yes, therapist's name:

BIRTH HISTORY

Was pregnancy full term? ❑ Yes ❑ No Apgar Score:

Complications:

Developmental Milestones:
❑ Held head up at _____ months ❑ Sat at _____ months ❑ Rolled over at _____ months
❑ Crawled at _____ months ❑ Pulled to stand at _____ months ❑ Walked at _____ months

AREAS OF CONCERN

Check all that apply:

Fine Motor Skills:
❑ Management of clothing fasteners
❑ Scissors skills
❑ Pencil grasp
❑ Coloring accuracy

Visual Motor/Visual Perceptual Skills:
❑ Legibility of handwriting
❑ Quality of drawings
❑ Quality of pencil pressure
❑ Frequency of letter/ Number reversals

Sensory Processing Skills:
❑ Difficulty with loud noises
❑ Bumps/Trips/Falls frequently
❑ Dislikes touching paint, soap, or play doh
❑ Dislikes wearing certain clothing
❑ Dislikes certain textures of food (crunchy, sticky, mushy)
❑ Dislikes swings or fearful of movement
❑ Difficulty staying seated in chair

Gross Motor Skills:
❑ Difficulty with running, jumping, hopping
❑ Difficulty with ball skills: catching, kicking
❑ Difficulty with novel tasks
❑ Poor balance

Organization of Behavior:
❑ Difficulty following directions
❑ Difficulty with attention to task
❑ Difficulty with self-regulation
❑ Social Skills

Self Care Skills:
❑ Feeding/Mealtime Skills
❑ Limited food repertoire
❑ Difficulty with dressing or grooming

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to client:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge.

_____ *Parent/ Legal Guardian Signature*

_____ *Date*

P.O. Box 29 • Old Mystic , Connecticut 06372 • (860) 245 - 1029 • www.ThrivingKidsTherapy.com

POLICIES & PROCEDURES

1. Account Responsibility: You are responsible for the full payment for services. Thriving Kids Therapy, LLC is a private provider and does not accept insurance.

2. Late Policy: Please be on time for your appointments. A professional staff member has been scheduled to treat your child specifically. If you are late by 10 minutes or more you may be required to reschedule or wait for the next available appointment. If your child is unable to be seen due to tardiness, you will be charged the no show fee below. If you are running late please call our office as soon as possible so we can attempt to accommodate you at a later time.

3. No Show & Cancellation Policy: Our professional staff plans according to scheduled visits. There is a $50.00 charge for no show or same day cancellations (cancellations with less than a 24 hour notice for Tue-Fri appointments and notice after 3pm Friday for Monday appointments). Patients who fail to attend their scheduled appointments for 3 consecutive visits will be discharged.

4. Closings & Inclement Weather: If Thriving Kids Therapy, LLC is closed, opened late, or closed early because of inclement weather, or other emergencies, phone calls will go out to clients affected by the change in schedule. We will do our best to be proactive and re-schedule ahead of time. In addition, NBC Connecticut will be notified, and this station will make an announcement. For closings or late openings, the station will be notified by 6:15 a.m.; for early closings, the notification will be by 10:15 a.m., if possible. As we are primarily an educationally based practice, we follow the local schools to determine closings.

5. Overdue Accounts & Fees: Payment is due upon receipt of a statement or being notified by the front desk. Accounts 30 days overdue may be assessed a re-billing fee of $5 for every additional statement sent. Accounts over 60 days overdue may be assessed a late fee of $25 and assigned to a collections agency.

6. Release of Liability and Informed Consent: I have read and understand the enclosed Release of Liability Waiver included in the intake paperwork. I understand the expected benefit of Occupational Therapy and I understand that I can refuse any procedure prior to its performance. I hereby consent to the procedures, which may be performed while I am a patient of Thriving Kids Therapy, LLC under the direction of a Licensed Occupational Therapist. This may include but not limited to: examination/evaluation, testing, and any other procedure falling under the scope of Occupational Therapy practice.

I UNDERSTAND AND ACCEPT THE ABOVE POLICIES AND PROCEDURES.

_____	_____
Child's Full Name	Child's DOB
_____	_____
Parent/Guardian Signature	Date

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SERVICE & CONSENT AGREEMENT

The following is an outline of the clinical services provided by Thriving Kids Therapy, LLC:

Service	*Description*
SCREENINGS	A screening may include an observation, a simple checklist or a parent interview, and includes one clinical hour (50 minute) session. A brief typed report will follow discussing your child's strengths and areas of concern. A formal evaluation including standardized testing may be recommended after a screening to gain specific insight on areas of concern. You may then pass the results on to your pediatrician for review.
EVALUATIONS	A formal evaluation requires two clinical hours and includes standardized testing and a complete written report. Test scores will help determine specific goals that will be followed during the course of therapy. We do an extensive evaluation involving clinical observations, parent and/or teacher interviews, and a variety of standardized assessments. A follow up visit is included/required to review the report and recommendations.
CONSULTATIONS	A consultation includes one clinical hour (50 minute) session with caregivers and/or teachers. A brief typed report will follow discussing your child's strengths and areas of concern. Additionally, suggestions for home or classroom activities and exercises will be included. Consultation services can be provided at our clinic, as well as in pre-schools, schools, vocational or community settings. Consultations are customized to the need of the child, family and staff.

I, _____ (parent/guardian), agree and accept the above terms and agreements and I give my consent for Thriving Kids Therapy, LLC to provide the following services for my child (check):

____ Occupational Therapy Screening
____ Occupational Therapy Evaluation
____ Occupational Therapy Consultation (School)
____ Occupational Therapy Consultation (Clinic)

_____ Child's Full Name

_____ Child's DOB

_____ Parent/Guardian Signature

_____ Date

_____ Printed Name

_____ SS# or DL#

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PAYMENT AGREEMENT

Thank you for choosing Thriving Kids Therapy, LLC as your Occupational Therapy provider. We are happy to provide services for you and your family. As we provide private Occupational Therapy services and *do not* accept insurance, the following agreement outlines the terms of payment between clients and Thriving Kids Therapy, LLC.

We strive to offer the highest quality of care, and we want to assure you that our fees accurately reflect the complexity of care rendered and the skill and expertise required. Our fees are comparable to those of other highly qualified specialists.

By signing this, you have agreed to be responsible for the payment of all charges incurred for therapy services for your child. All initial assessments/evaluations are billed at the flat rate of $720.00. All other services are billed at the rate of $90.00/clinical hour (50 minutes).

Invoices include documentation necessary for reimbursement from most insurance companies. This is not a guarantee that your insurance company will reimburse you in full. If you require other information on your invoice, please notify us and we will do our best to support you.

I UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR THE PAYMENT OF ALL CHARGES INCURRED AND I AGREE AND ACCEPT THE ABOVE TERMS AND AGREEMENTS.

_____	_____
Child's Full Name	Child's DOB
_____	_____
Parent/Guardian Signature	Date

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RELEASE OF LIABILITY WAIVER

I have informed myself of the policies, procedures and methods employed by Thriving Kids Therapy, LLC, and consent to the use thereof in providing treatment for my child.

I acknowledge that it is my responsibility to inform my child's physician that my child is participating in this treatment. I confirm that my child's physician is aware of my child's participation in Occupational Therapy. I voluntarily request that Thriving Kids Therapy, LLC provide treatment for my child.

I acknowledge the risks/potential risks of engaging in the Occupational Therapy program, which are similar to risks of play and activities of daily living. After considering the inherent risks, I feel that the possible benefits are greater than the possible risks. I voluntarily assume the risk for my child.

I hereby, as parent or legal guardian, intending to be legally bound, for my self, my heirs and assignees, executors or administrators, waive and release forever any and all claims for damages against Thriving Kids Therapy, LLC, its therapists, volunteers, employees, referring entities, subcontractors, property owners upon whose land the services are conducted, for any and all injuries and/or losses I or my child may sustain while voluntarily participating in the Occupational Therapy program.

I understand that Thriving Kids Therapy, LLC wishes to take reasonable steps to maintain the safety and well being of its participants. I confirm that I have disclosed all medical conditions of my child that may be affected in any way by the treatment. I acknowledge that I am responsible for updating this release if the medical condition of my child changes.

I acknowledge that I have been given sufficient time to ask questions, if any, concerning the nature and scope of this agreement. I have read the entire agreement and agree to it.

_____	_____
Child's Full Name	Child's DOB
_____	_____
Parent/Guardian Signature	Date