O.T. 4 kids, Inc. Gail E Huecker MS, OTR/L
772 Brawley School Road, Mooresville, NC 28117 Phone: (352) 303-6490 * Fax: (704) 664- 1156

Patient Intake Form

Child's Name: _____ Date of Birth: _____

Sex: M F Social Security #: _____ Main Phone: (___)_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Referring Physician: _____ Phone: (___)_____

Pediatrician and Other Specialists: _____ Phone: ( )_____

Diagnoses: _____ Onset Date: _____

Allergies, Medical Conditions: _____

_____

Parent or Guardian 1 Name: _____ Relationship to Patient: _____

Cell # (_____)_____ Occupation: _____Work #:(_____)_____

Email: _____Social Security #: _____ Date of Birth: _____

Parent or Guardian 2 Name: _____ Relationship to Patient: _____

Cell # (_____)_____ Occupation: _____Work #: (_____)_____

Email: _____Social Security #: _____ Date of Birth: _____

Insurance Information:

Check If Applicable: Medicaid _____ BCBS FL _____ Other_____

ID Number: _____Insurance Name: _____

Insured's Name: _____ Policy #: _____Group #: _____

Insurance Phone #: (___)_____

I, the undersigned, hereby consent to such treatment by the authorized personnel of O.T. 4 kids as may be dictated by prudent medical practice by the patient's illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Signature: _____ Date: _____

Relationship to Patient: _____

Welcome to O.T. 4 Kids!

Following are the office policies and rate information. I hope you find this information helpful and informative. Please do not hesitate to call with any question or concerns.

CANCELLATIONS: Cancellations must be made 24 hours in advance in order to allow the vacant slot to be filled. A $20 charge will be applied for cancellation made without prior notice (Medicaid patients excluded). This cancellation fee will not apply if the cancellation is due to unforeseen circumstances (illness, emergency, etc.) and/or the therapy session is re-scheduled.

NO-SHOWS: Clients who do not show up for their appointment and do not notify prior to the session will be subject to full session charge. Clients who have three (3) no-shows or repeated postponements are subject to discharge from services.

LATE FOR APPOINTMENTS: Clients who arrive late will be charged for the full session.

BILLING: O.T. 4 kids bills insurances that we are providers for directly. We do not file health insurance claims directly if we are not in network providers. Any necessary information or documentation for filing independently will be happily provided to the insured. It is recommended that you call you insurance carrier prior to your initial visit to verify benefits and limitations.

CHARGES:

Treatment Rates: $120.00 per hour

Interactive Metronome Rates: $110.00 per hour

Evaluation Rates: $150.00 per hour

Full OT Sensory Integrative Evaluation (with the SIPT or another equivalent test): $600.00

Court Documents: Additional information or supporting documents first 25 pages: $1 per page, each additional page $0.25

Court Appearances: If a therapist is subpoenaed or agrees to appear in court on behalf of a patient or their family at $120/hr fee will be billed to be payable by the guardian(s) of the patient.

Please note if there are any changes in insurance or payment you MUST let us know before the appointment as we need time to acquire the correct information or authorizations. Failure to notify us of any changes may result in the parent or guardian becoming responsible for any charges or fees at the above-mentioned rates.

I have read the above policies and agree to comply with the payment and cancellation policy.

_____ _____

Parent/Guardian Signature Date

_____

Client Name

O.T. 4 kids, Inc.

335 NE 10th Ave. * Crystal River, FL 34428 * Phone: 352-795-5552 * Fax: 352-795-7751
951 Candlelight Blvd. * Brooksville, FL 34601 * Phone: 352-345-8836 * Fax: 352-631-5509

General Information Confidentiality

- I wish my child to be called by the following name: _____
- I would like you to call me by my first name at any time I am in your office
  Name: _____
- You have my permission to use my last name while in your office: Yes / No
  Name: _____
- Do you want messages left on your answering machine at home/work regarding your child's treatment or do you prefer to speak to one of the staff or therapists directly. (If you choose to speak directly with a staff member or therapist, we will leave a message to call us back.)

  Answering Machine: _____

  Staff Member: _____
- May we call your home/office to confirm your child's appointment? Yes / No
- Please list family members/ friends who we may discuss your child's treatment with:

_____

_____

_____

_____

I have received a copy of the "Federal HIPAA Law" Agreements effective 4/14/03

Signed: _____ Date: _____

Patient Name:_____

EMERGENCY CONSENT FORM

This form is to authorize O.T. 4 Kids, Inc. and treating therapist(s) to authorize emergency treatment for my child to the Emergency Physician on duty in the event that I (Parent/Guardian) can not be located to give permission for treatment

Name of Child:_____

Date of Birth:_____

Allergies: _____

Parent/Guardian Signature: _____

Address: _____

Phone: _____

Witness Signature: _____

Emergency Contact Name: _____

Phone Number: _____ Relationship to Patient:_____

Appointment Reminders and Notifications

- Send appointment reminders to my email.
- Email: _____
- Send appointment reminders to my phone (standard message and data rates may apply)
- Phone Number _____
- Phone Carrier (AT&T, T- Mobile etc.): _____

- I would not like to receive appointment reminders

Times Available For Treatment:

Monday:_____
Tuesday:_____
Wednesday:_____
Thursday:_____
Friday:_____

Speech/Other Therapy Times:

Monday:_____
Tuesday:_____
Wednesday:_____
Thursday:_____
Friday:_____

O.T. 4 Kids, Inc.

Federal HIPAA Law regarding Health Information
Effective April 14, 2003

Our Responsibilities

Federal requires O.T. 4 Kids, Inc. and affiliated therapist to keep you or your child's health information private. The law also requires us to provide you with this notice. This notice explains our legal duties and privacy practices regarding protected health information. O.T. 4 Kids, Inc. must follow the terms of this notice. This notice becomes effective April 14, 2003.

You Are Not Required to Respond to This Notice

O.T. 4 Kids, Inc. may utilize you health information to inform you about treatment alternatives or health-related benefits and services.

The following are some examples of how we may use you or your child's health information:

- O.T. 4 Kids, Inc. may share your child's information with a company that reviews treatment records to assess the quality of care your child receives.
- O.T. 4 Kids, Inc. may send appointment reminders for your child's treatment schedule.

O.T. 4 Kids, Inc. may also utilize and disclose you or your child's health information as permitted by law, potentially including disclosures:

- To other government agencies that provide public benefits for determining eligibility and compliance.
- For public health, such as disaster relief, disease control; or to report abuse, neglect, or domestic violence.
- For health oversight, such as inspections, investigations, and audits.
- To avert serious threat to health or safety of a person or the public.
- To a law enforcement officer or a correctional institution that has your child in custody.
- To the federal government for national security, protective services, military, or veterans' activities.
- To coroners, medical examiners, and funeral directors; and for organ donations.
- As otherwise required by law.

Other uses or disclosures of you or your child's protected health information require your written authorization. If you give us your authorization, you may cancel it by writing to our office at the address listed on page 1 of this notice.

You have the following rights with respect to you or your child's protected health information:

- To see or obtain a copy of your child's treatment information that is maintained by O.T. 4 Kids, Inc. We may not be able to provide treatment information that includes psychotherapy notes, is part of a legal case, or is otherwise excluded by law. We may charge a copy fee.
- To request that O.T. 4 Kids, Inc. amend health information that is incorrect or incomplete.
- To request a list of where O.T 4 Kids, Inc. has sent you or your child's health/treatment information since April 14, 2003. The list may not include disclosures authorized by you; disclosures for treatment, payment, and health care operation; or other disclosures permitted by law.
- To request that O.T. 4 Kids, Inc. contact you at a different phone number or address, if contacting you about your child's treatment at your present location would endanger you.
- To request that O.T. 4 Kids, Inc. limit the use and disclosure of your child's treatment information. O.T. 4 Kids, Inc. is not required to agree to your request.
- To request additional copies of this notice

Contact Information

If you have any questions and/or wish to make a requesting regarding your child's treatment information, please contact our office at the phone number on this notice. We may ask you to make the requesting in writing.

Filing A Complaint

If you believe you or you child's privacy rights have been violated, you may file a complaint with O.T. 4 Kids, Inc. and the Secretary of the Department of Health and Human Services at the addresses below. You or your child will not be retaliated against for filing a complaint.

Administrator
O.T. 4 Kids, 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