Play To Learn Therapy, Inc.

P.O. Box 160591 ● Miami, FL 33116
(786) 553-1720 ● Lorin.Heagan@gmail.com

NEW PATIENT INTAKE FORM

PERSONAL INFORMATION

Child's Legal Name: ______________________________ Date of Birth: ____________________

Age: ________ Male: _____ Female: _____ Social Security: ____________________

PARENT INFORMATION

Mother or Legal Guardian: ______________________ DOB: ________ Phone: ________________

Father or Legal Guardian: ______________________DOB: ________ Phone: ________________

Parent Occupations: ____

Marital Status: Single ☐ Married ☐ Other ☐

Child resides with? ____________________ Who has custody of the child? ______________________

Siblings? ____

Best phone number and email to be reached at: ____

Physical Address: ____

Mailing Address: ____

If primary person bringing child to therapy is not listed above, please list name and contact phone number of that person. ____

EMERGENCY CONTACT			
Last Name:	First Name:	Phone:	
Address:	City:	State:	Zip:
Relationship:			

<u>INSURANCE INFORMATION</u> (please fill out ALL areas)

Primary Insurance:		Secondary Insurance:	
Policy No.:	Group No.:	Policy No.:	Group No.:
Claims Address:		Claims Address:	
Phone Number:		Phone Number:	
Insured's Name/DOB:		Insured's Name/DOB:	

Diagnoses with dates they were given: ____

____

____

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PRIMARY DOCTOR(S)

Name	Phone Numbers	City

THERAPIST(S)
Speech – Occupational – Physical – Other

Name	Type of Therapist	Phone	City	Hours/Week

OTHER CAREGIVER(S)

Name	Type	Phone	City

PRENATAL HISTORY

Maternal age at delivery: __________ years

Illnesses during pregnancy: ____

Medication during pregnancy: ____

Complications during labor and delivery: ____

Mode of delivery: C-section/vaginal? If C-section, explain why: ____

If vaginal delivery, did you have forceps/vacuum? ____

List any medication(s) during labor and delivery ____

Full term/Premature? (Circle one) How many weeks? ______ weeks

List any complications after delivery ____

Medications given to child during hospital stay? ____

Birth Information (Check/describe all those that apply):

Describe Child's Condition at/or immediately after Birth:

Premature ______ (If yes) Gestational age________ Apgars ________ NICU__________ Other________________

Ventilator ____ (If yes) How Long? ________ Jaundice ________ Heart Problems ______ Poor Suck ___________

Small for Gestational Age _________________ Large for Gestational Age __________________

Known Diagnosis (e.g. Down's Syndrome)____

Other Medical Complications____

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CHILD'S MEDICAL HISTORY

Please check all that are relevant:

Measles ☐ Mumps ☐ Pneumonia ☐ Chicken Pox ☐ Bronchitis ☐ BPD ☐ Reflux ☐ Allergies ☐
Head Injuries ☐ Tonsilitis ☐ Other ____________________

Please list any allergies: ____

Please list any current medications: ____

Please list any dates of hospitalization and reasons why: ____________________________________

____

Please list any surgical procedures (dates and reason): ______________________________________

____

- Does your child have asthma, hay fever, eczema, and/or rashes?
  If yes, please circle & comment if necessary.____
- Is your child allergic to any incense, essential oils, scents lotions or candles? If yes, please circle.
- Is your child on any special diet?
  If yes, please describe:____

Please list any pertinent family medical history: ____

Feeding (check all that apply)

Poor Suck ☐ Difficulty swallowing ☐ Difficulty chewing ☐ Gag/choke often ☐ Finger feeding ☐
Spoon use ☐ Required a feeding tube ☐ Reflux/vomiting ☐

List any other feeding concerns____

Is your child a picky eater? Y / N

Does your child dislike particular textures of food? Y / N

Hearing/Vision:

Has your child ever had a vision test? Y / N If yes, last date performed___________________________

Results____ Does your child wear glasses? Y / N

Has your child ever had a Hearing test? Y / N If yes, last date performed__________________________

Results ____ Does your child wear a hearing aid? Y / N

If yes, please indicate Left_______ Right________

PLAY TO LEARN
THERAPY INC

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Sensory History: (check yes or no)

	YES	NO
Do your child's hands, feet, and or tummy seem overly sensitive to touch?		
Does your child seem distractible or overactive?		
Does your child tolerate tooth brushing?		
Does your child hesitate on uneven surfaces?		
Does your child have difficulty positioning him/her in a chair?		
Does your child push/bump into other children?		
Does your child seem generally weak?		
Does your child have difficulty judging the height/depth of stairs?		
Does your child walk/go down stairs heavily (stomping feet)?		
Does your child have difficulty participating in sports with other children?		
Does your child have a fear of using playground equipment (see-saw, swing)?		
Does your child have difficulty catching himself/herself when falling?		
Does your child not hear certain sounds?		
Does your child respond negatively to certain sounds (running away, crying)?		
Does your child seem to be a picky eater?		
Does your child seem to always seek activities with pushing, pulling, jumping?		
Does your child demand only to wear certain clothes all the time?		
Does your child avoid getting hands messy?		
Does your child get bothered by face washing, hair brushing?		
Does your child spin, rock or hit self when distressed?		
Does your child have difficulty keeping eyes on task/activity?		
Does your child close one eye or tip head back when looking at something?		

Social History:

Who lives in the home with your child? ______________________________

Are any children in your family adopted? ______________________________

Pets in the home: ______________________________

Caregivers besides parents: ______________________________

List the people most important in your child's life: ______________________________

Recent changes: (losses, births, deaths, divorce, remarriage, moves, etc.): ______________________________

____

Recent travel: ______________________________

Child's response to these changes: ______________________________

Is your child involved in any sports, music or other activities? Please describe: ______________________________

____

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How does your child interact with other children/adults? ____

____

What makes your child…

Happy? ____

Sad? ____

Angry? ____

Stressed? ____

Any concerns you would like to share with us regarding your child? (His/her sensory processing, home or school, skills that are not age appropriate) ____

____

What goal would you like your child to work on this year? ____

____

Do you have any questions for us? ____

____

Please list any Behavioral Issues____

Are there any Behavioral strategies being used? ____

Please explain why you are seeking OT services: ____

____

Has your child ever had any previous Evaluations/Therapy? Y / N

If yes, please provide dates, facility where performed, type of therapy and reason(s). ______________________

____

Is there anything else that you would like us to know about your child? ________________________________

____

Educational History:

What school does your child attend? ____________________________________ Current grade level _______

How often does he/she attend school? ________________ days per week__________ hours per day

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What are your child's strengths in school? ____

____

What areas at school are the most difficult for your child? ________________________________

____

Thank you for taking the time to complete this form.

The information you have provided is valuable in assessing your child's developmental skills.

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Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Play To Learn Therapy Inc..

In addition, I hereby consent to the use and disclose of my child's personal health information for the purposes of treatment, payment and health care operations. Initial: ____________

Release of Information & Consent for Treatment

All information provided herein is true and correct.

I am aware of my child's diagnosis and wish him/her to receive treatment at Play To Learn Therapy, Inc. I permit its employees and all other persons caring for my child to treat him/her in ways they judge are beneficial to him/her. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care. Initial:______________

I give permission to Play To Learn Therapy, Inc. to release information, verbal and written contained in my child's medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries and all other related persons to my child's treatment or payment for services provided. Initial:______________

I understand that Play To Learn Therapy, Inc. also serves as a training and research facility and at times other therapists may be observing, handling, or have access to my child's medical information. I give my permission for Play To Learn Therapy, Inc. to use photographs and video taken of myself or my minor child during therapy sessions for educational, informational and promotional materials. Initial:______________

I authorize Play To Learn Therapy, Inc. to obtain medical records and/or professional information from my child's physician or other medical professional as it relates to my child's treatment. Initial:______________

The signature below certifies that I have read and understand the above information. Initial:______________

Summary Of The Florida Patient's Bill Of Rights and Responsibilities

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:
A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
A patient has the right to a prompt and reasonable response to questions and requests.
A patient has the right to know who is providing medical services and who is responsible for his or her care.
A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
A patient has the right to know what rules and regulations apply to his or her conduct.
A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
A patient has the right to refuse any treatment, except as otherwise provided by law.
A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment. A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
A patient is responsible for reporting unexpected changes in his or her condition to the health care provider. A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
A patient is responsible for following the treatment plan recommended by the health care provider.
A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Patient's Signature or Representative: ____________________ Date: ____________

PAYMENT GUARANTEE

I agree to pay Play To Learn Therapy, Inc. for the services provided to my child or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my child's treatments unless agreed to in writing by myself and a representative of Play To Learn Therapy, Inc.

Parent/Guardian signature____ Date: _______________

Social Security # _________-_______-__________

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FINANCIAL POLICY

Our staff verifies your insurance benefits prior to the onset of services as a courtesy to you. Although we strive to obtain the most accurate information possible, the quoted benefits from your insurance company are not a guarantee of payment. Should you need the detailed information about your coverage, please contact your insurance company directly.

You are responsible for your insurance deductibles, co-payments and supplies at the time of service.
In the event we receive a denial from your insurance company, and you choose to continue with therapy, payment is due at the time services are provided.

If payment is not received from your insurance company within 60 days from the date of filing, you will be responsible for payment in full. We will supply any documentation requested by your insurance company to expedite payment. We accept cash, checks, Visa and MasterCard.

There is a $25 service charge for all checks returned.

No shows will result in a $50 service fee, which will be due and payable on your next visit.

If you request your therapy charges to be billed to a party other than your insurance company, please provide the necessary billing information to our office. All billing directed to attorneys will have a lien placed on the account.

You are financially responsible for payment of services rendered. In the event the account becomes delinquent, and is therefore in default of payment, a collection fee will be added to the unpaid balance for the recovery of this debt.

If you have any questions or concerns regarding the financial policy, please speak to the Clinic Director or Patient Service Manager.

I understand that I am financially responsible to Play To Learn Therapy, Inc. for any changes incurred during the course of treatment and verification of benefits does not guarantee payment by the insurance company.
I hereby authorize payment be made directly to Play To Learn Therapy, Inc.

______________________________________ ____________________
Signature of Responsible Party Today’s date

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CANCELLATION/NO-SHOW POLICY

Please make all efforts to arrive for your child's Occupational therapy appointment on time. Your therapist has many people to see and makes every attempt to keep you on schedule. If you are unable to keep your appointment, please call and cancel so that we may adjust the therapist's schedule. We ask for at least a 24-hour notice for cancellations. We are aware that emergencies occur, but would prefer a cancelled visit to a "no show."

Should you miss an appointment with less than 24-hour notice or not show up for a scheduled appointment with no attempt to contact us, you will be charged $50.00 and further sessions will be suspended until we hear from you. If the therapist is unable to keep his/her appointment, you will be notified as soon as the therapist is aware and an alternate appointment will be made.

Please cancel appointments if your child is sick. **Your child must be free from fever, vomiting /diarrhea and on antibiotics as needed for at least 24 hours prior to his/her session.** Please note this policy is important to protect your child, other children, and staff.

Thank you in advance for your cooperation in this matter. Our mutual goal of providing quality therapy for your child can best be served if we all communicate changes in our schedules.

Please sign below to indicate awareness of this policy.

____

Authorized Signature Date

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WAIVER FORM

I, ________________________ the parent or guardian of _____________________ (thereafter referred to as "my child") give permission for my child to participate in Play To Learn Therapy, Inc. programs and services.

I hereby release Play To Learn Therapy, Inc. principal owners, therapists, employees and representatives and all other individuals or organizations acting on behalf of the Play To Learn Therapy, Inc. program, from any and all claims which I or my child may have, resulting from or in connection with my child's participation in Play To Learn Therapy, Inc. programs. This includes, but without limitation, any claim, demands or causes of action for injuries to my child, including but not limited to injuries resulting from the use of any play/therapy equipment during the program at the Play To Learn Therapy, Inc. center or at client's homes/school.

I understand that I should be present at all times during delivery of service to my child. If I choose not to, I understand that the aforementioned statements still apply in my presence or absence during the services provided.

This agreement is signed for the purpose of fully and completely releasing, discharging and indemnifying Play To Learn Therapy, Inc. in connection with their programs from all liability as herein described.

Signature: ____

Parent or Guardian signature & printed name   Date

Acknowledged By: ____

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I, ______________________ (Print), hereby authorize Play To Learn Therapy, Inc. to send me an appointment reminder via e-mail or text message using the following information.

Email reminders may contain patient or clinic information such as, but not limited to, patient first name and clinic location.

Patient / Guardian Contact Information:
(Please print clearly and legibly)

E-mail: ____

Cell phone: ____

Patient / Guardian (Print): ____

Signature: ____

Date: ____