



## Occupational Therapy Associates of Princeton, LLC

Tax ID: 20-1404092  
219 Wall Street, Princeton, NJ 08540  
Phone: (609) 921-1555, Fax: (609) 921-1065  
[www.otap.net](http://www.otap.net)

Welcome to Occupational Therapy Associates of Princeton, LLC (OTAP). We are very excited to begin working with your family to ensure the best treatment for your child. At OTAP, we wholeheartedly believe that the family is an integral part of the therapy process. To benefit from our expertise, we kindly ask that you complete this packet and include as much information as possible. Thank you.

CHILD'S NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, & ZIP CODE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: MALE FEMALE

PARENT "A" NAME: \_\_\_\_\_

ADDRESS (IF DIFFERENT FROM ABOVE) \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

PARENT "B" NAME: \_\_\_\_\_

ADDRESS (IF DIFFERENT FROM ABOVE) \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

SIBLINGS: (NAMES & AGES) \_\_\_\_\_



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Occupational Therapy Associates of Princeton, LLC is part of the Horizon Blue Cross/Blue Shield network. We do not bill out-of-network insurance companies directly and our services are not guaranteed to provide insurance coverage. We are not affiliated with any medical/hospital facility. We are a private facility. You may have benefits for an out-of-network provider or belong to a POS/PPO plan that covers outside facilities. We will give you an invoice at the time of services. You are responsible for submitting claims to your insurance company. If an insurance reimbursement is sent to our office, we will immediately send the check back to the insurance company and notify you.

**INDIVIDUAL’S FINANCIAL RESPONSIBILITY - I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments are due at time of service. In the event that my health plan determines a service to be “not payable”, I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured or out-of-network, I agree to pay for the services rendered to me at time of service.**

\_\_\_\_\_  
Signature Required

**\*\*Exception: Blue Cross/Blue Shield participants (see page 2.)**

Will you be seeking reimbursement from your insurance company?      YES                      NO

(If yes, we ask that you complete the insurance information below in case we need to contact your insurance company on your behalf.)

NAME OF INSURED: \_\_\_\_\_

INSURED’S SSN # / MEMBER ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

INSURED’S EMPLOYER: \_\_\_\_\_ INSURED DOB: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

INSURANCE COMPANY PHONE #: \_\_\_\_\_ CONTACT: \_\_\_\_\_

**I authorize consent for the release of any medical information necessary for insurance purposes.**

\_\_\_\_\_  
Signature Required



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Occupational Therapy Associates of Princeton, LLC (OTAP)  
collaborates with families and professionals to build strong intervention.

HOW DID YOU HEAR ABOUT OTAP? \_\_\_\_\_

IF YOU WERE REFERRED:  
WHO REFERRED YOU? \_\_\_\_\_

PROFESSION: \_\_\_\_\_ PHONE: \_\_\_\_\_

FULL ADDRESS: \_\_\_\_\_

**OTAP has my permission to send a thank you to my referral source including my child's name.**

\_\_\_\_\_  
Signature Required

child and family. We stress that consistency is essential for meeting your child's goals and continuity of carryover in therapy.

### PAYMENT OF SERVICES:

Payment is due at the time services are rendered. We accept cash, check and credit cards (Visa, MasterCard, American Express and Discover). Returned checks are subject to a \$35.00 returned check fee.

### BILLABLE SERVICES:

While there is no ordinary charge for a brief telephone consultation, more lengthy or complex situations may result in charges. Some reports and consultations may also result in charges. School observations and meetings are also subject to charge.

### ILLNESS:

Please do not have your child attend treatment if he/she is not feeling well. Our facility must be germ-free to maintain the health of our clients and staff. If your child is not well enough to go to school, he/she is not well enough to attend therapy. Please note our cancellation policy and be sure to give us a call in advance

**I acknowledge that I have read and understand my responsibility to pay for services. By signing this agreement, I agree to the terms of this document.**

\_\_\_\_\_  
Signature Required

\_\_\_\_\_  
Printed Name



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Occupational Therapy Associates of Princeton, LLC (OTAP) is dedicated to finding the answers that will enable our children to participate fully in life regardless of their circumstances.

**I give Occupational Therapy Associates of Princeton permission to contact me regarding participation in a research project.**

\_\_\_\_\_  
Signature Required

### **OTAP CANCELLATION POLICY**

We strive to provide excellent care to you, your family and all our patients and in order to do so effectively and efficiently, we have an appointment system that sets aside ample time for each patient. Please discuss schedule changes at the end of your appointment with your therapist and the front desk administrator.

We understand occasional changes are necessary due to illness, vacations, etc. Please call our office within 24 hours of a scheduled appointment if you need to cancel or reschedule that appointment. This allows for clients to reschedule into additional openings therapists may have.

“No-shows” and late cancellations inconvenience those individuals who need access to our care in a timely manner. In an effort to reduce the number of such occurrences, we have an **Appointment Cancellation Policy**.

Our policy is as follows:

1. Please provide our office 24-hours’ notice in the event you need cancel or reschedule your appointment. Failure to provide us 24 hours’ notice will result in a charge of your usual session rate.
2. If you are more than 15 minutes late for your appointment, the appointment cannot be kept and will be considered “missed” and a \$50 rate will apply.
3. We encourage our patients to gather all necessary information regarding their insurance coverage well in advance of the appointment. Cancelling with less than 24 hours’ notice due to complications with insurance coverage will also result in a \$50 missed appointment fee.



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Our automated system communicates with our patients as a courtesy reminder. Unfortunately, no system is fool proof. It is ultimately the patient's responsibility to remember their scheduled appointments. We simply ask that you respect our time, as we respect yours.

We are happy to work out scheduling problems with you. Please let us know if you are experiencing a problem with your current schedule. If therapy needs to be canceled for a couple of weeks, such as an extended trip, we will hold your therapy spot for up to three weeks. We will then have to place you on the waiting list and will fit you back in the schedule as soon as we can.

I hereby understand the above cancellation policy and agree to abide by it.

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

### VIDEO AND PHOTO RELEASES

Occupational Therapy Associates of Princeton, LLC are a research and education based facility. Therefore, we often video or photograph children and/or family members participating in treatment and/or research projects. The video or photographs may include interviews, assessments, treatment, or group activities. The rights, titles and interests of these materials belong to Occupational Therapy Associates of Princeton, LLC, which reserves the right to edit the material.

I, (please print your name) \_\_\_\_\_ voluntarily consent to the taking of photographs or video of myself and/or my child (please print your name)

\_\_\_\_\_.

I understand that these photographs or videos may be used for educational purposes, scientific purposes and/or media publications. I realize that the photographs or videos may be used to create educational training tapes and may be used at seminars, workshops, literature or publications, on website, webcasts/video on demand presentations. Some video or photographic material may be included in future training tapes or books that may be sold for the treatment of children. Specific names of children and family members seen in the photos or videos will not be disclosed.

**I give permission for use of photographs or video to be used for educational purposes, for news, or other media, for webcast, video on demand and for training tapes by Occupational Therapy Associates of Princeton, LLC.**

\_\_\_\_\_  
Parent / Guardian Signature Required

\_\_\_\_\_  
Parent/ Guardian Printed Name



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### CLINICAL RELEASE OF CONFIDENTIAL INFORMATION

To ensure success in therapy, Occupational Therapy Associates of Princeton, LLC utilizes a team approach with all disciplines in treatment. The release and sharing of information will include, but not be limited to conversations, therapy sessions, records, reports, evaluations, treatment planning and factual information regarding myself and the client. This is done to assist OTAP in working with both our clients and their families.

I, (please print your name) \_\_\_\_\_ do hereby authorize Occupational Therapy Associates of Princeton, LLC permission to discuss my child's case with the interdisciplinary professionals involved in my child's care, and to release any relevant clinical information to those professionals if requested.

\_\_\_\_\_  
Child's Full Name

\_\_\_\_\_  
Parent/Guardian Signature

If applicable:

I, (please print your name) \_\_\_\_\_ do hereby authorize Occupational Therapy Associates of Princeton, LLC permission to discuss my child's treatment, progress, and home assignments with others that accompany my child during occupational therapy sessions.

\_\_\_\_\_  
Child's Full Name

\_\_\_\_\_  
Parent/Guardian Signature



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If applicable:

I, (please print your name) \_\_\_\_\_ do hereby authorize Occupational Therapy Associates of Princeton, LLC permission to maintain verbal/written contact with my child's teachers, other therapists, service coordinators, and others that work with my child on a regular basis.

\_\_\_\_\_  
Child's Full Name

\_\_\_\_\_  
Parent/Guardian Signature

### **CLINICAL RELEASE OF CONFIDENTIAL INFORMATION**

In authorizing the release of confidential information with your child's interdisciplinary team, below please list your's child's team:

PROFESSION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE & ZIP CODE: \_\_\_\_\_

PROFESSION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE & ZIP CODE: \_\_\_\_\_

PROFESSION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_



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CITY, STATE & ZIP CODE: \_\_\_\_\_





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**NOTICE OF PRIVATE PRACTICE HEALTH INSURANCE  
PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

I, (please print your name) \_\_\_\_\_ have reviewed the Notice of Private Practice under the Health Insurance Portability and Accountability Act (HIPAA) and have accepted the privacy practices, legal duties, and rights concerning my health information. I also understand that the information supplied is required by applicable federal and state law to maintain the privacy of my health insurance.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



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**CONFIDENTIAL PERSONAL HISTORY**

CHILD'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SCHOOL ATTENDING: \_\_\_\_\_

FULL ADDRESS: \_\_\_\_\_

GRADE IN SCHOOL: \_\_\_\_\_ TYPE OF CLASSROOM: \_\_\_\_\_

DOES YOUR CHILD HAVE AN IEP?      YES                  NO

DOES YOUR CHILD HAVE A 504 PLAN?      YES                  NO

DATE OF LAST FORMAL EVALUATION: \_\_\_\_\_

DID YOUR CHILD RECEIVE EARLY INTERVENTION SERVICES: \_\_\_\_\_

**CHILD'S PHYSICIAN AND HEALTH CARE PROVIDERS (INCLUDING PEDIATRICIAN):**

NAME: \_\_\_\_\_ PROFESSION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE & ZIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ PROFESSION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE & ZIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ PROFESSION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE & ZIP: \_\_\_\_\_ PHONE: \_\_\_\_\_



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**PREGNANCY:**

WERE THERE PROBLEMS WITH FERTILITY:      YES                      NO      COMMENTS: \_\_\_\_\_

WERE THERE COMPLICATIONS:      YES                      NO      COMMENTS: \_\_\_\_\_

SHOCK:                                      YES                      NO      COMMENTS: \_\_\_\_\_

SEVERE STRESS:                              YES                      NO      COMMENTS: \_\_\_\_\_

LOSS OF LOVED ONE:                      YES                      NO      COMMENTS: \_\_\_\_\_

ACCIDENT:                                      YES                      NO      COMMENTS: \_\_\_\_\_

HEALTH PROBLEMS:                      YES                      NO      COMMENTS: \_\_\_\_\_

BED REST:                                      YES                      NO      COMMENTS: \_\_\_\_\_

OTHER:    YES                      NO      COMMENTS: \_\_\_\_\_

DID MOTHER SMOKE:                      YES                      NO      COMMENTS: \_\_\_\_\_

DID MOTHER DRINK ALCOHOL:      YES                      NO      COMMENTS: \_\_\_\_\_

DID MOTHER TAKE MEDICATION: YES                      NO      COMMENTS: \_\_\_\_\_

PREVIOUS PREGNANCY COMPLICATIONS:      YES                      NO

COMMENTS: \_\_\_\_\_

**LABOR**

DESCRIBE YOUR EXPERIENCE DURING LABOR AND DELIVERY: \_\_\_\_\_

FULL TERM BIRTH:      YES                      NO      COMMENTS: \_\_\_\_\_

PREMATURITY (SPECIFY WEEKS PREMATURE): \_\_\_\_\_



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TYPE OF DELIVERY (VAGINAL / C-SECTION): \_\_\_\_\_

FORCEPS USED:      YES                      NO      COMMENTS: \_\_\_\_\_

SUCTION USED:      YES                      NO      COMMENTS: \_\_\_\_\_

DELIVERY POSITION (I.E., BREECH): \_\_\_\_\_

BIRTH WEIGHT: \_\_\_\_\_ APGAR RATING (IF KNOWN): \_\_\_\_\_

CRIED IMMEDIATELY:      YES                      NO      COMMENTS: \_\_\_\_\_

REQUIRED SPECIAL TREATMENT (I.E., HAD JAUNDICE, REQUIRED OXYGEN, NICU): \_\_\_\_\_

BIRTH INJURIES: \_\_\_\_\_

DID MOTHER HAVE POST PARTUM DEPRESSION: YES                      NO      COMMENTS: \_\_\_\_\_

**ADOPTION**

DESCRIBE THE CIRCUMSTANCES SURROUNDING THE ADOPTION: \_\_\_\_\_

AGE WHEN ADOPTED: \_\_\_\_\_ WHAT COUNTRY: \_\_\_\_\_

IS CHILD AWARE OF HIS/HER ADOPTION: \_\_\_\_\_

**INFANCY/TODDLERHOOD:**

IN FIRST 2 YEARS, DESCRIBE CHILD'S

PERSONALITY (happy baby, colic...etc) \_\_\_\_\_

SLEEPING (position when sleeping) \_\_\_\_\_

FEEDING (did you change formula often? Special formula? Breast fed) \_\_\_\_\_



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ACTIVITY LEVEL (hyper, non attentive, quiet, shy...) \_\_\_\_\_

SEPARATION ANXIETY: \_\_\_\_\_

BREAST FED: YES NO COMMENTS: \_\_\_\_\_

HEALTH PROBLEMS: YES NO COMMENTS: \_\_\_\_\_

THUMB SUCKING/PACIFIER: YES NO COMMENTS: \_\_\_\_\_

COLIC: YES NO COMMENTS: \_\_\_\_\_

PREFER CERTAIN POSITIONS (INFANCY) YES NO COMMENTS: \_\_\_\_\_

DISLIKE LYING ON STOMACH: YES NO COMMENTS: \_\_\_\_\_

DISLIKE LYING ON BACK: YES NO COMMENTS: \_\_\_\_\_

ABLE TO SOOTHE: YES NO COMMENTS: \_\_\_\_\_

ENJOYED BOUNCING: YES NO COMMENTS: \_\_\_\_\_

BECAME CALM BY CAR RIDES/SWINGS: YES NO COMMENTS: \_\_\_\_\_

BECAME SICK/AGITATED BY CAR RIDES/SWINGS: YES NO COMMENTS: \_\_\_\_\_

TOE WALKER: YES NO COMMENTS: \_\_\_\_\_

IS YOUR CHILD UP-TO-DATE WITH VACCINATIONS: \_\_\_\_\_

### **DEVELOPMENTAL MILESTONES:**

ROLLING OVER (approximate age): \_\_\_\_\_ WALK (approximate age): \_\_\_\_\_

SAT UP (approximate age): \_\_\_\_\_ CRAWLED (approximate age): \_\_\_\_\_

DRINK FROM A CUP (approximate age): \_\_\_\_\_ CHEWED SOLID FOODS (approximate age): \_\_\_\_\_

SAY WORDS (approximate age): \_\_\_\_\_ POTTY TRAINED (approximate age): \_\_\_\_\_

### **CHILDHOOD ILLNESS/PROBLEMS:**

MEDICAL DIAGNOSIS (LIST ALL THAT APPLY): \_\_\_\_\_



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MEDICAL PRECAUTIONS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

HISTORY OF EAR INFECTIONS: \_\_\_\_\_ AGE: \_\_\_\_\_

TREATMENT: \_\_\_\_\_

(Please respond with None/ A Couple / Many : Age: and Comments)

RESPIRATORY PROBLEMS: \_\_\_\_\_ ASTHMA: \_\_\_\_\_

HIGH FEVERS: \_\_\_\_\_ MENINGITIS: \_\_\_\_\_

ADENOID PROBLEMS: \_\_\_\_\_

FREQUENT COLDS: \_\_\_\_\_ STREP THROAT: \_\_\_\_\_

SKIN PROBLEMS/ECZEMA: \_\_\_\_\_

SEIZURES: \_\_\_\_\_

GI PROBLEMS: \_\_\_\_\_ BROKEN BONES: \_\_\_\_\_

HOSPITALIZATIONS: \_\_\_\_\_

SERIOUS ACCIDENTS / INJURIES: \_\_\_\_\_

**MEDICATIONS:** (LIST ALL MEDICATIONS YOUR CHLD IS CURRENTLY TAKING)

MEDICATION: \_\_\_\_\_ PURPOSE: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ PURPOSE: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ PURPOSE: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ PURPOSE: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ PURPOSE: \_\_\_\_\_

**ACTIVITIES OF DAILY LIVING:**

DRESSING



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(IS YOUR CHILD INDEPENDENT IN DRESSING? CAN YOUR CHILD MANIPULATE FASTENERS? DOES DRESSING REQUIRE CUEING TO STAY FOCUSED? IS YOUR CHILD SENSITIVE TO TEXTURES, TAGS, ETC? DOES YOUR CHILD HAVE DIFFICULTY TRANSITIONING BETWEEN SEASONAL WEAR?)

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### FEEDING

(DOES YOUR CHILD FEED HIM/HERSELF? DO THEY TYPICALLY FINGER FEED OR USE UTENSILS? DOES YOUR CHILD SIT AT THE TABLE WITH THE FAMILY? IS HE/SHE A PICKY EATER? IF YES, PLEASE LIST FOODS HE/SHE EATS? IS YOUR CHILD ON ANY SPECIAL DIETS? ARE YOU CONSULTING WITH A NUTRITIONIST?)

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### TOILETING

(IS YOUR CHILD TOILET TRAINED? WHAT AGE? IF NO, HAS A PROGRAM BEEN SET UP TO ADDRESS THIS? IS YOUR CHILD ABLE TO MANAGE HIS/HER OWN CLOTHING? DOES YOUR CHILD HAVE ACCIDENTS?)

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### BATHING

(Does your child prefer baths or showers? Is the child independent in washing self / hair?)



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### BRUSHING TEETH

(Is your child independent? Does your child gag? )

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### WASHING HANDS / FACE

(Is your child independent? Do they prefer being messy? Do they notice when they are dirty and get visibly upset?)

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### HAIR BRUSHING

(Is your child independent? If applicable, will your child tolerate clips, bands, or bows?)

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### SLEEPING/BEDTIME

(Is there a bedtime routine set up? Is your child more agitated or hyper before bedtime? Does your child sleep in his/her own bed or with parents? Does your child sleep through the night? Sleepwalking? Snoring? Nightmares / Terrors?)

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### PLAY SKILLS





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Describe your child's play skills? Can they initiate play? Are they a follower / leader? Can they transition from one activity to the next? If not, what strategies to you use to transition the child? Does your child prefer a few close friends or a large group of people? Does your child tend to control the play group? Does your child prefer interacting with children his/her age or a younger/older person?

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How would you describe your child's coordination (e.g. clumsy, excels at sports etc.)

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### SOCIAL SKILLS

Has your child ever participated in social skills groups? If yes, which ones and where? Did you notice a change from the group?

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### TRANSITIONS

Describe how your child approaches and explores new environments? Does your child require preparation when transitioning between activities, people, and / or places?

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### ATTENTION SPAN

Is your child highly distractible? What strategies does your child use to sustain attention/focus to a task?

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### BEHAVIORS

Does your child participate in any atypical behaviors / self stimulatory behaviors? (hand flapping, twitching, jumping, obsession with the mirror, or objects)

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### SENSORY COMPONENTS

#### TOUCH / TACTILE

(Does your child have any sensitivity to touch? Light touch? Deep touch? What is your child's preference in clothing? How does your child use touch to explore? Does your child prefer to be barefoot? Does your child tolerate tags and/or seams?)

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#### SOUND/AUDITORY

(Does your child have any sensitivity to sound? Are they easily distracted by background noises? Do they ignore when their name is called? What kind of music do they prefer? Has your child ever participated in specialized auditory programs? Does your child tolerate birthday parties? What is the reaction to loud sounds?)

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### VISION/VISUAL

Does your child wear glasses? What is the tolerance to bright lights? Dim lights? Can your child sustain visual attention? Can they track an object? Does your child get visually distracted?)

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### TASTE/GUSTATORY/ORAL

(Is your child a picky eater? Is there a certain preference to taste or texture? Will your child try new things? Does your child gag when smelling / tasting foods? Does your child have pica?)

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### MOVEMENT / VESTIBULAR

(Does your child favor active or sedentary activities? Do they understand safety or take risks? What is your child's behavior when his / her feet leave the ground? Would you describe your child a clumsy? Is your child fearful of rides? Does your child prefer being upside down?)

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### PRESSURE / PROPRIOCEPTION

Does your child tend to bump into others? Do they tend to fight using their hands? Does your child understand personal space? Is your child clumsy, fall a lot?

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What do you feel are your child's greatest strengths?

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What do you feel is your child's greatest challenge?

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What are your goals for your child? What do you wish OTAP achieves while your child is in therapy? Please be as specific as possible.

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Do you have any questions for your therapist?

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