Occupational Therapy Associates of Princeton, LLC

Tax ID: 86-3661549

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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) ____

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

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

Occupational Therapy Associates of Princeton, LLC (OTAP) is dedicated to providing quality services to your 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

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.

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

______________________________________ ______________________________________
Printed Child's Name Date

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

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.

I ____ ____
Child's Full Name Parent/Guardian Signature

PROFESSION: ____________________

ADDRESS: ____

CITY, STATE & ZIP CODE: ____

PROFESSION: ____________________

ADDRESS: ____

CITY, STATE & ZIP CODE: ____

PROFESSION: ____________________

ADDRESS: ____

CITY, STATE & ZIP CODE: ____

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

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: ____________________

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): ______________________________

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: ___________________________________

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____

____

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) _________________________________

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): ____

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
(IS YOUR CHILD INDEPENDENT IN DRESSING? CAN YOU CHILD MANIPULATE FASTENERS? DOES DRESSING REQUIRE CUING 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 YOU 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?)

BATHING

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

BRUSHING TEETH

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

WASHING HANDS / FACE

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

HAIR BRUSHING

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

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

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?

ATTENTION SPAN

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

BEHAVIORS

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

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?)

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?)

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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