# Welcome!

Date:___________________

Patient Information

Name___________________________________________________________________________________

(Last) (First) (Middle)

Date of Birth ___________________ Sex: ☐ Female ☐Male Parent's Names________________

Address_________________________________________________________________________________

(Street) (City) (State) (Zip code)

Home Phone #______________________ Cell #_____________________ Work #______________________

Emergency Contact

Name ___________________ Relation to the patient _____________ Home# ___________ Other#_________

If in an emergency, I, ____________________________ hereby authorize O.T. Works. Inc. and it's staff to provide emergency medical care for my child,________________________.

Parent Signature: ______________________ Date Signed: ____________ Patient name: _________________

Any details you would like to share with? (ex. Allergies?) ___________________________________________

_________________________________________________________________________________________

Physician Information

Referring Physician's Name _________________________ Phone#________________ Fax#_______________

Patient's Diagnosis _______________________ Prescription for services - ☐ Bring with you? ☐ faxed?

Insurance Information

**Primary Insurance Carrier**

Insurance Co. Name ______________________________ Member ID # ______________________________

Policy/Group # __________________________________ Effective Date _____________________________

Policy Holder's Name ___________________ SS#_____________________ Date of Birth________________

Relationship to Patient_____________________________ Employer Business Name ____________________

**Secondary Insurance Carrier**

Insurance Co. Name_______________________________ Member ID # _____________________________

Policy/Group #___________________________________ Effective Date ____________________________

Policy Holder's Name ___________________ SS#_____________________ Date of Birth________________

Relationship to Patient_____________________________ Employer Business Name ____________________

We want to welcome your family and start off by thanking you for choosing our facility as Your therapy clinic. O.T. Works, Inc. is a family friendly facility with a staff of team players with the same mission as to “Serve all those who seek and need our services, with quality care, to the best of our abilities”.

O.T. Works, Inc. provides Occupational Therapy for children with disabilities. If you ever have any questions or concerns, please feel free to ask a staff member. We look forward to getting to know you and helping in any way we are able. O.T. Works, Inc. believes in being one universal family, and we are so excited that you decided to join ours!

# Extended Patient Info

O.T. Works, Inc.

Your child's comfort, esteem, and success are very important to us. Please take the time to fill out the following to avoid any discomfort or embarrassment.

**Patient Name:**_____________________

**Birth History**

Full-term Premature

Other / Comments

______________________________________________________________________

______________________________________________________________________

**Medical History**

Any complications, problems, illnesses, allergies etc?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Surgeries?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Medications taken or currently taking?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Developmental History**

Did your child crawl: Yes No At what age?______

If your child is walking, at what age did he/she start?____________________

Why has your child been referred for therapy services?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

What are your concerns regarding your child?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

What, if any, specific behaviors or skills would you like addressed?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

# Consent for Use and Disclosure of Protected Health Information

Patient's Full Name:_________________________________ Parent's Name: _________________________

Address:______________________________ City:_____________ State:________ Zip Code:__________

Daytime number:_________________ Evening number:__________ Cell Phone:______________________

1. I understand that my Protected Health Information may be used and disclosed to carry out treatment, payment, or health care operations.
2. I have the right to request restrictions on the use of my Protected Health Information. I understand that O.T. Works. Inc. is not required to agree to these requested restrictions.
3. I have been informed of O.T. Works. Inc.'s Privacy Notice required by the Privacy Regulations, and have been given a copy of the Privacy Notice and the opportunity to review the Privacy Notice before signing this Consent.
4. I understand I have the right to revoke this consent any time, except to the extent that O.T. Works. Inc. has taken action in reliance on it. Any revocation must be signed and dated by the undersigned and provided to O.T. Works. Inc.
5. I consent to the administration and performance of all treatments and services provided and administered by O.T. Works. Inc. and acknowledge that I have been informed of the risks, benefits, and alternatives to the treatments and services.
6. I consent to O.T. Works, Inc. obtaining information regarding me in assignment of benefits including but not limited to Insurance Companies, Government Health Care, Veteran's Administration, and Workmen's Compensation carriers.
7. I consent to payment of services to O.T. Works, Inc. for any services provided, as applicable.

*By signing below I have read the above and fully understand the terms and conditions.

Client/Parent/Guardian Signature __________________________________________ Date_______________

Witness / Staff Signature ________________________________________________ Date_______________

# O.T. Works, Inc.

## -Attendance Policy-

To accommodate everyone who is need of our services, we have made our hours as flexible as possible. We also promise to get all children scheduled without any long delays. In order to do this we implement the following policy:

If you do not show for your scheduled appointment and you fail to call and cancel, you will be considered a No-Show which will result in a $25 fee. You must pay this $25 fee at the time of your next visit or you will not be seen that day.

If you No-Show for 2 consecutive appointments, we hold the right to remove you from the schedule. We will give your slot to another child in need. You will then have to call and confirm that we have an available slot before returning.

To cancel, you must call by 9:00am the day of your appointment or you will be considered a No-Show.

You may cancel up to a maximum of 2 times in a one-month period. Once you have met your maximum we hold the right to remove you from the schedule. We do understand certain circumstances the families face, so we will use our discretion in these situations.

If and when you are removed from our schedule, you will be placed at the bottom of our waiting list. Once your name has been reached on the waiting list you will be given a time that is not considered one of our prime times.

If you are more than five minutes late for 2 consecutive appointments, you will be charged a $5.00 late fee for every time you are late.

If you have Medicaid, by signing this form, you are aware that you will be charged a No-Show fee, not Medicaid, if you do not call or show up to your previously scheduled appointment.

By signing this form you are agreeing that you have read and fully understand this policy and take responsibility of the financial account of this patient.

Patient's Name_____________________________________DOB____________

Parent/ Guardian's Signature__________________________Date ____________

Staff / Witness Signature_____________________________ Date ____________

# O.T. Works, Inc.

1309 E. Market St. Suite 5
Nappanee, IN 46550

3127 Northview Dr.
Elkhart, IN 46514

Phone (574) 773-7733

Fax (574) 773-7733

## Occupational Therapy & Physical Therapy Fees

| | | |
|---|---|---|
| Evaluations: $250.00 (To Insurance) | $100.00 (If billed) | $75.00 (Pay @Time of Service) |
| Treatments: $200.00 (To Insurance) | $50.00 (If billed) | $40.00 (Pay @Time of Service) |

## Speech Therapy Fees

| | | |
|---|---|---|
| Evaluations: $450.00 (To Insurance) | $200.00 (If billed) | $100.00 (Pay @Time of Service) |
| Treatments: $400.00 (To Insurance) | $100.00 (If billed) | $50.00 (Pay @Time of Service) |

**School Visits ($50 Flat Fee)** If you go to the school for an IEP mtg, to observe a child, etc. let the parent know that there is a fee that will be billed to the parent. If you want to do this in your free personal time then there will not be a charge.

**Phone Visits ($25 Flat Fee)** If you have a phone interview / conversation with the school, therapist, or another professional for the sake of your patient, let the parent requesting the service know that there will be a fee billed to the parent.

## No-Shows will be charged a $25 fee

| | | |
|---|---|---|
| Weighted Animal | = | Range from $10 - $20 |
| Weighted Vests | = | $10.00 |
| Weighted Blankets | = | $10.00 |
| Sensory Boxes | = | Range from $10 - $20 |
| Chewy (with handle) | = | $10.00 |
| Chewy (w/out handle) | = | $10.00 |
| Visual Schedule | = | $20.00 |

Client/Parent/Guardian Signature ________________________________________ Date_______________

Witness/Staff Signature _______________________________________________ Date_______________

# O.T. Works, Inc.

The Therapy Playce

1309 E. Market St. Ste. 5 | 3127 Northview Dr.

Nappanee, IN 46550 | Elkhart, IN 46514

Phone 574-773-7733 Fax 574-773-7133


## Medical Photography Consent Form

Patient's Name:________________________________________ DOB:____________________

PATIENT CONSENT

I,

________________________________________________________

First name Last name

consent to medical images being made of my child/dependant.

I agree that duplicates may be made for the referring doctor.

I agree that the images may be:
(Please check below to show consent)

| | Yes | No |
|---|---|---|
| placed in my medical record for future treatment | ____ | ____ |
| faxed to my treating health professional | ____ | ____ |
| used by health professionals for education and Training | ____ | ____ |

By signing below, I confirm that I understand this consent form.

____________________________________________ ______________

Signature of Patient/Parent or Guardian: Date:

____________________________________________ ______________

Signature of Witness: Date:

# Notice of Privacy Practices - Receipt
# HIPPA Law

We understand that medical information about you or your family's health is personal. We are committed to protecting medical information about you and your family. We create a record of the care and services our patients receive at O.T. Works. Inc. We require these records to provide quality care and to comply with certain legal necessities. This notice applies to all records of care generated by O.T. Works, Inc.

The Notice of Privacy Practices pamphlet we are giving you today outlines your rights to your medical records and how we protect your private information.

In summary, the notice covers the following topics:

1) Who will follow these practices.
2) Circumstances under which we are required by law to release information about you.
3) How we may use and disclose information about you for treatment at O.T. Works. Inc.
4) Your rights:
    a. To inspect and copy your medical record
    b. To request an amendment of information in your medical record
    c. To request an accounting of disclosures
    d. To request restrictions
    e. To request confidential communications
5) Procedure to file a complaint if you believe your rights have been violated.
6) Who to contact at O.T. Works. Inc.
7) Our procedure to provide you with a new version of this notice, if it revised.

**Patient/Patient Rep.**__________________________________________ **Date** ______________

**Witness Signature** ___________________________________________ **Date** ______________

**Reasons given by Patient/Patient Rep. for refusing to sign this notice**

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**O.T. Works, Inc.**

**Notice of Privacy Practices - Receipt**

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Fax: (574) 773-7133

## Records Release Authorization

I hereby authorize and request you to release to:

| Facility Name | Facility Address | Facility Phone# | Contact Name |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

I give permission for you to be able to communicate over the phone regarding my child's treatment and needs, and share the complete medical records and/or information in your possession, concerning my child's illness/diagnosis and/or treatment for the duration my child is under your care.

Name ______________________________ Date_________________

Address _____________________________________________________

Signature____________________________________________________
(If relative, state relationship)

Witness_____________________________________________________

HIPAA Fee Structure For Medical Records

Copies per sheet: $0.50
Second Disclosure within 6 months: $25.00 Minimum fee
Privacy Office: Katie Peat, OTR
Privacy Contact: Holly Finchum/Michelle Garner