Garden State Speech Therapy

Pediatric and Adult Speech / Swallowing and Feeding Disorders
Pediatric Occupational Therapy

316B Kinderkamack Rd. Westwood, NJ 07675
208 Harristown Rd, LL2. Glen Rock, NJ 07452

tel: 201-297-9167 / fax: 201-829-0817
www.gardenstatespeech.com

Pediatric Occupational Therapy Intake Form

Child's Name____

Birthdate:____ Age:_____

Parent/Guardian Name(s): ____________________________________

Address:____

____

Phone Number: ____

Email Address: ____

Pediatrician: ____

Referred by:____

Would you like GSST to share the results of the evaluation with your primary care provider/referring physician: YES NO

Siblings Name and Ages:

____

What are your primary concerns/goals for therapy regarding your child?

____

____

____

garden state
SPEECH THERAPY

What are your child strengths? Likes/Dislikes?

___

___

School Name:

___

Grade:

___

Hand preference: Right   Left   Both

Does your child receive special instruction or have an established IEP?   no   yes School based therapy?   OT   PT   Speech and Language

Medical History

Any difficulties during pregnancy or delivery?   No   Yes If Yes please specify:

___

Length of pregnancy: _____________   Birth was: Vaginal   Caesarian   Breech

Chronic ear infections? no   yes   tubes placed _________________ sets of tubes

Current prescribed medications:

___

Known food allergies:

___

Special Diet (GFCF, Ketogenic, pureed food only, tube feeding, etc.):

___

Medical precautions:

___

___

Diagnosis given by other health care professionals? Name of Dr.?

Hospitalizations, date, and length of stay:

Surgeries?

Currently receiving services from other health care professionals: Psychologist

PT Speech and Language Nutritionist Behavioral Specialist Other

Names:

Developmental History

Please check all the developmental milestones that your child achieved:

rolling sitting alone creeping on all 4's pull to stand walking

first word: ____________(age) combined words:_____________(age)

finger feeding eating with a spoon cutting with a knife cutting with scissors

jumping hopping on one foot riding a bike

Developmental milestones were met: within typical age ranges delayed

garden state SPEECH THERAPY

Please check the amount of assistance needed for your child to complete the following:

Self care:	Independent (completes without help)	I with assist 50% or more	Dependent (total assist needed)
Takes off pants			
Puts on pants			
Takes off shirt			
Puts on shirt			
Buttons			
Zippers			
Snaps			
Puts on shoes			
Takes off shoes			
Ties shoes			
Puts on socks			
Takes of socks			
Toileting			
Bathing Routine			
Tooth Brushing			
Scooping w/ spoon			
Speak w/ fork			
Drinks from cup			
Drinks from straw			

Describes your child at present:

	Yes	No	Sometimes
Mostly Quiet			

Overly Active			
Tires Easily			
Talks Constantly			
Too impulsive			
Restless			
Stubborn			
Resist to change			
Fights Frequently			
Usually Happy			
Exhibits temper tantrums			
Clumsy			
Nervous Habits			
Wets Bed			
Poor Attention			
Easily Frustrated			
Unusual Fears			
Rocks Self Frequently			
Difficulty falling asleep			
Difficulty staying asleep			
Sluggish in the morning			

Social and Occupational History

Does your child:

	Often	**Sometimes**	**Rarely**
Socialize with family and close friends?			
Communicates needs/wants effectively?			
Hard to make friends?			
Tend to interact/play with younger children?			
Enjoy time alone?			
Tolerate change in routine?			
Tolerate running errands?			
Enjoy eating in restaurants?			
Enjoy attending Birthday parties?			
Enjoy attending family functions?			

Please provide any additional information that will help to better understand your child:

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Financial Agreement

______ I hereby give Garden State Speech Therapy, LLC authorization to file claims for services rendered on my behalf. Any claims that are not paid or authorized by the insurance carrier will be my responsibility.

_____ I authorize the release of any medical or other information necessary to process all claims.

_____ I understand that if payment is not issued by the insurance company within 45 days of the initial filing, I am responsible for following up with my insurance carrier and may be responsible for any payments not paid by my insurance carrier to Garden State Speech Therapy, LLC.

______ Invoices are due within 15 days of receipt. A 20% late fee will be added to all late bills.

_____ If patient responsibility payment is not received within 30 days, therapy services might be put on hold. All balances more than 30 days old will be charged to the credit card on file.

_____ I understand that if patient responsibility payment is not made within 60 days, my/my child's appointment time will be forfeited until the balance due is paid in full and therapy services might be terminated. I understand that delinquent accounts may be referred to collections, incur interest collection and attorney's fees for which I will be responsible. Garden State Speech Therapy, LLC does not guarantee the same time slot once the payment has been made.

_____ I understand that a valid credit card on file is required for all scheduled appointments.

_____ GSST will re-submit denied insurance claims twice (2 times). All denied claims thereafter will be billed to the client at billed rate. GSST will make every effort to assist with insurance appeals upon request.

_____ All returned checks will incur a $30 service fee.

_____ I understand that it is my responsibility to inform the office of any insurance changes. Any charges incurred after the termination date of insurance policy are my responsibility

_____ All patient responsibility payments are due at the time of service

Date: ________________ X____

Print Name: ____

Parent/Guardian for: ____

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Attendance and Cancelation Policy

Consistent attendance of therapy sessions is paramount for progress. We offer consistent scheduling to all clients, with time slots reserved for each client. Our therapists make a commitment to their clients' progress, we ask that our clients make the same commitment by maintaining their attendance. We will make every effort to schedule make ups for all missed sessions. Make up sessions are offered based upon availability of therapists.

_____ We require 24 hour notice for cancellations. All cancelations of office visits **less than 24 hours in advance** and **no-shows** will incur a **$50 charge**. For traveling appointments, the full rate will be charged. **The $50 cancelation fee will be waived if the appointment is rescheduled and attended within 2 weeks. The $50 no-show fee will not be waived and no-show appointments will not be rescheduled**

_____ **Two (2) canceled and not rescheduled sessions in any 10-week period will result in appointment time loss at the discretion of GSST management. Attendance rate of 80% is expected**

______ **2 consecutive no-shows will result in appointment time loss**

______ I understand that cancelation and no-show fees cannot be billed to my insurance and are my responsibility.

______ Sick children will be sent home. We will do our best to reschedule the appointment.

I have read and understood the attendance and cancelation policy. I hereby accept the attendance and cancelation policy in full.

Date: ________________ X____

Print Name: ______________________________________

Parent/Guardian for: _____________________________________

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Consent and Acknowledgement

Name of client:____

Consent for care and treatment: As (self/parent/legal guardian), I hereby consent to necessary evaluation, procedures, and/or treatments prescribed by the occupational therapist as is necessary in their judgment. I understand that I/my child is under the care of an occupational therapist. I authorize the release of medical information to Garden State Speech Therapy, LLC for continuity of care.

HIPAA Notice of Privacy Practices: Garden State Speech Therapy, LLC will use and disclose personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law.

___________________________________ ___________________________

Signature Date

____

Print Name

____

Relationship to client

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All Information Will Remain Confidential

Patient's name____

Name on card: ____

Billing Address: ____

Credit Card Type: _____Visa ______Mastercard ______Discover

Credit Card Number: ____

Exp. Date:______________ CVV/Security Code:______________

____ I choose to pay my outstanding balance with a credit card. A valid credit card is required to be on file for this option. Please provide the following information.

____ I understand that all balances more than 30 days overdue will be charged to my credit card on file

I hereby authorize Garden State Speech Therapy, LLC to charge the credit card listed above for services rendered. I agree that all sessions booked will be charged at the corresponding rate as stated in the Service Agreement. I agree to keep valid credit card information on file with Garden State Speech Therapy, LLC and to immediately notify Garden State Speech Therapy, LLC if there are any changes to my credit card information. I agree to pay these charges according to my credit card agreement and not to cancel any valid charges, according to this agreement.

____ _______________________

Signature Date