INFORMATION Form

TINY HANDS THERAPY SERVICES:

318 Trichardts Road, Parkdene, Boksburg
14 Wiek road, Bardene, Boksburg
100 Algernon Road, Norwood, Johannesburg
074 823 4321
info@tinyhandstherapyservices.co.za

Tara Thomson
Occupational Therapist
B.Sc. OT (WITS), M.Sc. OT (WITS)
HPCSA: OT 0081680 PR NR: 0623490

CLIENT INFORMATION / CHILD'S INFORMATION

Full Name :

Date of Birth : ___ ___ / ___ ___ / ___ ___
d d m m y y

Gender :

PARENT / GUARDIAN INFORMATION

Full Name :

Address :

ID Number

Email :

Contact Number:

Married Status :

MEDICAL AID DETAILS

Medical Aid

Plan

Med aid No

Dependent code

I confirm that all the information below is true and correct, and I understand that I am responsible for any costs not covered by the medical aid. Hiermee bevestig ek dat die besonderhede korek is, en dat ek verantwoordelik vir die vereffening van die rekening sal wees. Please note: Medical aids sometimes pay less than what we charge. Sometimes they do not pay at all. Please contact your Medical Aid prior to starting sessions to determine what they will cover. No refund will be given if the medical aid does not refund you.

Do you wish for the practice to claim directly through your medical aid? **YES** ☐ **NO** ☐

Signature of client
Parent or guardian in the case of minors

Signature of person responsible for the account

CONSENT

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TERMS AND CONDITIONS

Assessment: Therapy will start with an assessment which includes the below to take place on pre-agreed dates. Assessment of your child: a range of age appropriate standardised and play-based assessments are used. The duration of the assessment depends on multiple factors such as age, response to assessment tasks and the assessments that need to be completed (Range: 1 to 4 hours – may be broken up into multiple sessions). Feedback parent meeting: it is preferable that both parents attend this meeting. The results of the assessment are discussed in detail and recommendations are made based on the assessment findings. Report: a comprehensive written report is included in the assessment fee which is sent a minimum of 2 weeks following the assessment. Teacher consultation (if your child is attending school or a playgroup): may be necessary to understand how your child functions in different environments (telephonic or face-to-face). This is not part of the assessment fee charged and will be arranged separate to assessment. The assessment invoice will be emailed to the parents within two business days after the assessment of the child has been completed in full and prior to the feedback parent meeting. PAYMENT IS DUE AND PAYABLE ON THE FIRST BUSINESS DAY (in South Africa) AFTER THE ASSESSMENT INVOICE DELIVERY DATE. The assessment report will not be emailed and consequent therapy, if required, cannot commence until payment is made in full. Sometimes we may ask that a portion of the assessment fee is payed upfront on the day of the assessment.

Therapy: Therapy consists of a carefully planned and graded treatment of your child. Please remember that: The duration of therapy cannot be determined beforehand. Speed of progress is dependent on each individual child, the severity of the identified concerns, and the consistency of sessions.
·Generally, the time a child spends in therapy can be greatly reduced by the completion of activities at home (as recommended by your Therapist). Please dress your child comfortably (tracksuit or shorts) as the sessions are physically active. A reassessment will be done after one year of therapy if therapy has not been terminated before then. The assessment tasks will be completed over regular treatment sessions and the Therapist will give you feedback for which you will be charged the regular session charge and the "In depth Reassessment Fee". The Therapist reserves the right to terminate therapy due to irregular attendance.
Reports:: Progress reports will be issued after a six-month therapeutic period upon request. A final report will always be issued when therapy is terminated. Reports will be charged for as set out in the Schedule of Fees (Annexure A).

Fees:
The cost of both the assessment and therapy is calculated using codes accepted by the Medical Schemes Council and may be altered from time to time.
Please note sessions can be claimed directly from your medical aid if you wish, however, you will be responsible for any levies, or costs which your medical aid does not pay for, Medical aids sometimes pay less than what we charge. Sometimes they do not pay at all. Please contact your Medical Aid prior to starting sessions in order to determine what they will cover. No refund will be given if the medical aid does not refund you. A copy of the statement will be sent to you by the 5th of the following month, if you have not received this statement please contact your therapist immediately Hands on therapy will assume that all statements have been received if you do not notify your therapist. The Practice fees are subject to an annual increase, effective from 1 January. Should any alteration of fees be brought into effect, written notice will be provided via email. Professional fees are principally time based and are charged in respect of all time spent on each individual client. This includes therapy sessions, record keeping of sessions/consultations, preparation for therapy sessions and consultations, feedback and telephone calls with parents, teachers or any other professional involved with the case. Please refer to Annexure A for the Schedule of Fees. NOTE: Although a session rate is fixed, different billing codes are used to make up the rate. For example, "Individual Therapy 45 minutes": this rate is made up of multiple billing codes such as an individual treatment code (45-minute session) and a recommendations code; or, individual treatment code (45-minute session), observations and screening, and parent communication code. The separate billing codes align with the time spent with the child for the provision of comprehensive therapy services charged for. Services provided by the Practice will be reflected on an invoice rendered on/about the 5th of every month and emailed to the Parents email addresses as provided on page 1 ("Invoice Delivery Date"). PAYMENT IS DUE AND PAYABLE ON THE FIRST BUSINESS DAY (in South Africa) AFTER INVOICE DELIVERY DATE. The bank details are reflected on the invoice. .Please note, assessment or progress reports will not be forwarded until your account is settled in full. if payment is not received by the end of the month, reminder notifications will be sent out. If payment is not received by the 10th of the following month, therapy will be immediately discontinued and will only resume once your account is paid in full. The Practice reserves the right to terminate therapy due to non-payment without notice. The Practice reserves the right to charge interest on overdue accounts. The interest charged will be at a rate determined in accordance with Section 1 (2) of the Prescribed Rate of Interest Act, 1975. If accounts are paid within the same month as issued, interest will ordinarily not be applied. If you neglect to settle your account, a third party will be contracted to recover outstanding monies. Any administrative or legal costs involved in the collection of monies owed will be for your account. Any and all legal costs will be recoverable on an attorney and own client scale. If you have any special circumstances that prevent you from paying, please let the Therapist know immediately so that a payment plan can be arranged.

Involvement and Communication: As the Parent, you are entitled and encouraged to maintain regular contact with the Practice in order to keep up to date with your child's treatment and progress. You are encouraged to attend therapy sessions to gain a better understanding of the therapeutic process; please arrange this with your Therapist. A WhatsApp group will be created with both Parents (where possible) which will be used for updates and sharing of information pertaining to your child's therapy. Kindly note that WhatsApp has embedded end-to-end encryption which ensures only the persons you're communicating with can read or listen to what is sent, and nobody in between, not even WhatsApp. The success of therapy depends on your cooperation and being honest. Please inform your Therapist of any significant events/changes that affect your child. If you are uncertain about anything, please make an appointment with or email your Therapist to discuss.
Confidentiality and express consent: Every person that receives therapy in the Practice has the right to confidentiality (this means to have your personal information kept private, even from family members and other significant individuals; e.g. educators, the school). The Practice takes the protection of personal information seriously as required in terms of the Protection of Personal Information Act No. 4 of 2014 ("POPIA", as may be amended or substituted from time to time), as well as in terms of our role as a health care provider. Your and our rights and obligations are set out in the Privacy Notice which you acknowledge, understand and accept (as attached). Nothing that you share with your Therapist will be passed on to anyone, unless: You agree that your information can be shared (e.g. with a school teacher of any other person/entity involved with assisting your child). Signed consent will be obtained for this. The law on medical aids forces the Practice to provide certain information to the medical aid. Your invoice will therefore include personal information, specific treatment codes and diagnostic codes. When we receive an order from a court to disclose your information, we have no choice but to provide it. Or when a specific law (legislation/regulation) makes it compulsory to report things such as TB, cancer or child abuse/neglect. Communication with other relevant health professionals, insofar as it is necessary and in the interests of your child. Signed consent will be obtained for this.
Cancellations: If your child attends therapy during school hours, please inform your Therapist by 08h00 should your child be absent on their regular therapy day. To accommodate absenteeism or school outings, your Therapist may change the scheduled day of therapy so your child receives their recommended session/s per week. This shall be communicated with you. If you bring your child to therapy, please inform your Therapist of cancellation at least four hours prior to the scheduled time. Late arrivals will be charged for in full and your child will receive therapy for the remaining duration of the scheduled session. Failure to cancel sessions as set out above will result in an "Appointment Not Kept" fee being charged (50% of the regular session fee). Your medical aid will not reimburse you for this fee.

Domicilium Citandi et Executandi and Jurisdiction: The respective parties choose as their domicilium citandi et executandi for the purposes of legal proceedings and for the purposes of giving or sending any notice provided for or necessary in terms hereof, the addresses as set out within their details provided above on page 1. Any notices, formal communication and/or process (whether legal or otherwise) may be sent to the Email addresses provided herein (or updated from time to time in writing) and where sent, shall be deemed to have been received and read by the recipient twenty-four hours after the Email was sent. The parties consent to the jurisdiction of the Magistrates Court (or Small Claims Court where applicable) in Boksburg for all legal proceedings.
Undertaking: We understand that part of the assessment or treatment may require the use of video recording and we give the Practice permission to use video recording for the purpose of assessment, clinical observation, training, and record keeping. This will be managed in terms of the Privacy Notice. We also understand that each child will respond differently to therapy intervention and no timeframe or results can be guaranteed. I
I**ndemnity**, Release and Waiver of Liability: We recognise that therapy includes active physical exercise which can lead to injuries. We acknowledge that our child will participate at his/her own risk and by signing this document, we indemnify Tara Thomson and her respective employees and representatives working within the Practice from any and all loss, costs, claims, injury, damage or liability sustained or incurred by my child resulting from his/her participation and/or resulting from any act or omission of any agent, employee or representative of the Practice. Hands on Therapy (the "Practice") is an association of registered Occupational Therapists (the "Therapists"). Being a patient at the Practice under the treatment of a Therapist and by signing below you agree to the above terms and conditions. :

____

Signature of client
Parent or guardian in the case of minors

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BACKGROUND INFORMATION

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BACKGROUND INFORMATION

School name:

Telephone:

Grade:

Name of teacher:

Assessment requested by:

Reason for referral / Describe your concerns:

What is your child's behaviour like at home?

Prenatal History

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PRENATAL HISTORY

Were there any complications during pregnancy or delivery?

Was the pregnancy full term? **Yes** ☐ **No** ☐ **state weeks** ____

Type of delivery : **Natural vaginal** ☐ **C/S elected** ☐ **C/S emergency** ☐

What was the child birth weight? ____

Were there any complications following the delivery?

Were there any concerns with feeding/sleeping/behaviour (e.g. colicky)

Did you use a :

Walking ring **Yes** ☐ **No** ☐ **Hours per day** ____

Jolly Jumper **Yes** ☐ **No** ☐ **Hours per day** ____

DEVELOPMENTAL AND MEDICAL HISTORY

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DEVELOPMENTAL HISTORY

At what age did your child:

Sit alone

Crawl

Did your child crawl normally on all 4's? Yes No

Walk

Was the crawling phase very brief ? Yes No

Start talking

MEDICAL HISTORY

Present state of heath, does your child:

Show undue fatigue Yes No

Have headaches Yes No

Other:

Give details about previous hospitilisations/iillness

Does your child have allergies? Yes No
What are they?

FAMILY HISTORY

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FAMILY HISTORY

If separated/divorces with whom does the child live:

How often does the child see his/her other parent:

Name and age of siblings

Is there a family history of learning difficulties? Please describe.

OTHER

Please comment on your child's:

Sleep:

Feeding:

Behaviour:

Your primary concerns and your hopes/goals for therapy

Thank you