New Patient Intake Form

Today's Date:

Child's Last Name: Child's First Name:

DOB: Age: Male / Female

Language(s): Current School:

Siblings (Name, Age):

Parent/Guardian Name:

Relationship to Child:

Address:

State: Zip: Email:

Cell Phone: Alternate Phone:

Occupation: Marital Status:

Second Parent Guardian Name:

Relationship to Child:

Address:

State: Zip: Email:

Cell Phone: Alternate Phone:

Occupation: Marital Status:

Child's Doctor: Phone:

Other health providers working with your child:

Child's Insurance Provider:

Member #: If Medicaid, Specify Branch:

Who referred you to Building Beyond Basics?

What are your child's strengths?

What are your child's weaknesses?

New Patient History Form

Child's Name: DOB:

Birth History

What hospital was your child born at?

Was your child born full term? Yes / No If no, at how many weeks?

Length and weight at birth? Inches lbs. Oz.

Any complication with pregnancy or birth for the mother?

Any injury with pregnancy or birth for your child?

Small for Gestational Age (SGA)? Yes / No Breech? Yes / No

Did your child require forceps or suction for delivery? Yes / No

Was your child delivered via Cesarean Section? Yes / No Emergency / Scheduled

After birth did your child require extra hospitalization? Yes / No

For how long? NICU? Yes / No

Just after birth did your child present as jaundice? Yes / No

Apgar score at 1 minute: Apgar score at 5 minutes:

Did your child receive any diagnosis before leaving the hospital from birth?

Infancy History

Was your child breastfed? Yes / No If so, for how long?

Did your child have difficulty learning how to "latch on" to the breast? Yes / No

Was there a strong suck during feeding? Yes / No

Did your child tire rapidly during feeding? Yes / No

Did your child frequently spit up after feeding? Yes / No How often?

What formula was/is used?

Was/Is the formula whey based? Yes / No Soy based? Yes / No

Rice based? Yes / No Other type of base? Yes / No

Did your child show any intolerance to formula? Yes / No

Type of intolerance:

Did your child show any intolerance to infant foods? Yes / No

Type of intolerance:

As an infant, would you describe your child as any of the following?

Cried often, fussy, irritable? Yes / No / Sometimes Comments:

Non-demanding? Yes / No / Sometimes Comments:

Alert? Yes / No / Sometimes Comments:

Quiet? Yes / No / Sometimes Comments:

Passive? Yes / No / Sometimes Comments:

Active? Yes / No / Sometimes Comments:

Enjoyed being held? Yes / No / Sometimes Comments:

Resisted being held? Yes / No / Sometimes Comments:

Floppy when held? Yes / No / Sometimes Comments:

Tense when held? Yes / No / Sometimes Comments:

Had good sleep patterns? Yes / No / Sometimes Comments:

Had irregular sleep patterns? Yes / No / Sometimes Comments:

Early Childhood History

Did your child have difficulty learning to take a bottle? Yes / No

Describe:

Did your child have difficulty manipulating an infant spoon/fork? Yes / No

Describe:

Did your child arch back and/or throw their head back when upset? Yes / No

Describe:

Did your child tend to be stiff in early childhood or infancy? Yes / No

Describe:

Did your child enjoy cuddling and soften into your body when held in early childhood or infancy? Yes / No

Describe:

Did your child prefer certain positions in early childhood or infancy? Yes / No

Describe:

Did your child dislike lying on their stomach in early childhood or infancy? Yes / No

Describe:

Did your child enjoy car rides in early childhood or infancy? Yes / No

Describe:

Did your child enjoy infant swings in infancy? Yes / No

Describe:

Did your child tend to be generally compliant in early childhood or infancy? Yes / No

Describe:

Did your child ever have little white bumps on their skin, especially on the backs of their arms, elbows, or knees, in early childhood or infancy? Yes / No

Describe:

Did your child crave certain foods in early childhood or infancy? Yes / No

Describe:

Did your child get chronic ear infections in early childhood or infancy? Yes / No

Describe:

Developmental Milestones

In the following developmental milestones, please give the age of your child and comment on anything unusual.

Lift head - Age: Comments:

Roll over - Age: Comments:

Sit alone - Age: Comments:

Crawl - Age: Comment:

Was the crawling phase brief? Yes / No

Did your child crawl on hands and knees? Yes / No

Crawl only backwards? Yes / No

"Commando / belly" crawl? Yes / No

Put weight through their arms and "bunny hop"? Yes / No

Scoot while sitting on their bottom? Yes / No

Use a walker or exer-saucer? Yes / No

Chew on solid food - Age: Comment:

Walk - Age: Comment:

Cruise - Age: Comment:

Run - Age: Comment:

Drink from a cup - Age: Comment:

Say words - Age: Comment:

Say sentences - Age: Comment:

Toilet-trained bladder - Age: Comment:

Toilet-trained bowels - Age: Comment:

Undress themselves - Age: Comment:

Dress themselves - Age: Comment:

Manage zippers, buttons, snaps - Age: Comment:

Tie shoes - Age: Comment:

Climb upstairs - Age: Comment:

Step downstairs - Age: Comment:

Climb out of crib - Age: Comment:

Feed themself - Age: Comment:

Developed a dominant hand - Age: Comment:

Right / Left

Medical History

Has your child had any of the following or been immunized for any of the following? Please provide dates.

Meningitis?	Diagnosis date:	Immunization date:
Measles?	Diagnosis date:	Immunization date:
Chicken Pox?	Diagnosis date:	Immunization date:
High Fevers?	Diagnosis date:	
Mumps?	Diagnosis date:	Immunization date:
Whooping cough?	Diagnosis date:	Immunization date:
Scarlet fever?	Diagnosis date:	Immunization date:
Convulsions?	Diagnosis date:	
Diabetes?	Diagnosis date:	
Lung difficulties?	Diagnosis date:	
Heart difficulties?	Diagnosis date:	
Seizures?	Diagnosis date:	How often:
Allergies?	Diagnosis date:	To what?
	Reaction?	
Excessive vomiting?	Diagnosis date:	
Tuberculosis?	Diagnosis date:	Immunization date:
Polio?	Diagnosis date:	

Does your child have a history of an irregular heartbeat (i.e. arrhythmia, murmur)? Yes / No

Any other diagnoses or major illnesses?

Any physical injuries?

Has your child ever been hospitalized? Yes / No Date:

Diagnosis:

Does your child currently have (or had in the past) any casts, braces, or splints?

Does your child have any assistive devices (i.e. glasses, prosthetics)?

Does your child frequently catch colds? Yes / No

Does your child have problems with their bowels (i.e. constipation, diarrhea, gas)? Yes / No

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Does your child have a vision problem? Yes / No

If so, what is the diagnosis?

Has your child had an eye evaluation? Yes / No Date:

Optometrist / Opthamologist:

Does your child have a hearing problem? Yes / No

If so, what is the diagnosis?

Has your child had a hearing evaluation? Yes / No Date:

Audiologist / ENT:

Has your child had tubes surgically placed in their ears? Yes / No Right / Left

Date: Are the tubes still in place? Yes / No

Has your child ever been evaluated by a physical therapist? Yes / No

Name: Date:

Has your child ever been evaluated by an occupational therapist? Yes / No

Name: Date:

Has your child ever been evaluated by a speech and language therapist? Yes / No

Name: Date:

Has your child ever been evaluated by a psychologist? Yes / No

Name: Date:

Has your child ever been evaluated by a neurologist? Yes / No

Name: Date:

Has your child ever been evaluated by a counselor? Yes / No

Name: Date:

Has your child ever been evaluated by any other professional? Yes / No

Name: Date:

Has your child ever been diagnosed as failed to thrive? Yes / No Date:

Please list all prescription medications, over the counter medications, vitamins, or supplements your child is currently taking.

Name: Dose: Reason:

Name: Dose: Reason:

Name: Dose: Reason:

Name: Dose: Reason:

Present

What is your child's dominant hand? Right / Left / Unknown

What are your child's favorite foods?

Do any foods elicit a gag response?

What are your child's favorite toys? What do they do with these toys?

How long does your child play with the toy?

Who does the child prefer to play with?

What activities does your child least enjoy?

What extracurriculars is your child involved with?

What activities do you see your child avoid?

_____

Would you describe your child currently as any of the following?

Mostly quiet? Yes / No / Sometimes Comment:

Overly active/restless? Yes / No / Sometimes Comment:

Easily car sick? Yes / No / Sometimes Comment:

Easily fatigued/tired? Yes / No / Sometimes Comment:

Talks constantly? Yes / No / Sometimes Comment:

Very impulsive? Yes / No / Sometimes Comment:

Resistant to change? Yes / No / Sometimes Comment:

Overreactive? Yes / No / Sometimes Comment:

Very stubborn? Yes / No / Sometimes Comment:

Fights frequently? Yes / No / Sometimes Comment:

Usually happy? Yes / No / Sometimes Comment:

Has frequent temper tantrums? Yes / No / Sometimes Comment:

Clumsy? Yes / No / Sometimes Comment:

Difficulty separating from primary caretaker? Yes / No / Sometimes Comment:

Has nervous habits or tics? Yes / No / Sometimes Comment:

Wets the bed? Yes / No / Sometimes Comment:

Walks on tip-toes when excited or anxious? Yes / No / Sometimes Comment:

Easily frustrated? Yes / No / Sometimes Comment:

Has unusual fears? Yes / No / Sometimes Comment:

Difficulty bonding with peers? Yes / No / Sometimes Comment:

Difficulty learning new motor tasks? Yes / No / Sometimes Comment:

Difficulty learning new academic tasks? Yes / No / Sometimes Comment:

Picky eater? Yes / No / Sometimes Comment:

Sensitive to touch/texture? Yes / No / Sometimes Comment:

Sensitive to smells? Yes / No / Sometimes Comment:

Sensitive to sounds? Yes / No / Sometimes Comment:

Sensitive to light? Yes / No / Sometimes Comment:

Sensitive to movement? Yes / No / Sometimes Comment:

Sensitive to taste? Yes / No / Sometimes Comment:

Sensitive to anything else? Yes / No / Sometimes Comment:

Are there any precautions the evaluating therapist should be aware of?

Have there been any recent large changes in the family or in the child's life?

What is your major concern, if any?

Are there any other details about your child you would like to share?

Evaluation and Treatment Authorization

I, _____, authorize and request that occupational therapy services be provided to my child, _____, by Kristen A. E. Bohan, Inc. I am making this authorization as my child's legal guardian. I am aware of my rights to my child's medical records through HIPPA regulations. I am aware that in the process of occupational therapy evaluation or treatment, the OT/COTA may use a variety of activities including but not limited to feeding, balance/vestibular exercises, novel social environments, therapy dogs, full body sensory integration, etc. I understand that if I have any concerns, questions, or reservations that I am to speak with my child's therapist directly.

Please indicate one choice below:

☐ This Authorization shall remain in effect until revoked by me in writing

OR

☐ This Authorization is for today only

_____ _____

Signature Date

Release of Protected Health Information and Request for Records

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip:_____

This release will authorize those persons listed below to receive / release private health information or otherwise confidential yet necessary information from my records.

Provider Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

Email: _____

Information to be Released:

- □ Treatment Plan
- □ History and Physical
- □ Evaluations
- □ Lab Work
- □ Progress Notes
- □ School Records and Testing
- □ Other pertaining to Occupational Therapy treatment and claims

Purpose of Release:

□ Continued Treatment
□ Reimbursement
□ Disability
□ Other: _____

Information is to be released to Kristen A. E. Bohan Inc.

Name of Parent / Guardian: _____

This is a continuous disclosure for one year after discharge.

I hereby authorize and direct Kristen A. E. Bohan, Inc. to receive all or part of the patient's medical records, consultation notes, and other Protected Health Information from the above named provider.

I hereby authorize and direct Kristen A. E. Bohan, Inc. to send all or part of the patient's medical records, consultation notes, and other Protected Health Information to me via e-mail or fax.

I acknowledge the following:

I have the right to revoke this authorization at any time by sending written notification to Kristen A.E. Bohan Inc.. I understand that the revocation of this authorization is not effective to the extent that of prior to receiving my written revocation notice.

I understand that any Protected Health Information forwarded to me pursuant to this Authorization may be subject to unauthorized interception and is no longer protected under HIPAA.

I acknowledge that Kristen A. E. Bohan, Inc. will not condition the patient's care or treatment on whether I sign this Authorization.

_____ _____
Parent / Guardian Signature Date

Notification of Office Policies

Registration Forms:

Prior to scheduling an appointment with Kristen A.E. Bohan, Inc., you will need to fill out an Intake Form, Credit Card Authorization Form if applicable, Private Health Information Release, Authorization to Evaluate and Treat, as well as a signed copy of this Office Policies Form. In addition, we need a copy of your child's insurance card if we are submitting to CMS on your behalf. These forms can be brought with you to the evaluation, sent by email to Kristenbohan@gmail.com, or via fax to 888-411-9766.

Initials _____

Missed Appointments:

As a private clinic, we understand illness, injury, and family conflicts occur. We have a multitude of patients with flexible times and they are eager to take your time slot but early notification is key, as this allows us to keep productive and to avoid continuously raising prices. Please send a text to 941-545-3744 as soon as you realize you will be unable to keep an appointment. We do appreciate you trying to limit the spread of sickness. If your child has a fever, lice, or anything else easily spread, your child cannot attend therapy. If you miss your appointment without prior text/call 3 times, you will be charged a fee for every future missed appointment without appropriate notification and are subject to losing your time slot.

Initials _____

General:

While we attempt to have comfortable relationships and communication with all of our patients and their families, we request that families arrive to our office as close to the scheduled appointment time as possible and leave when finished meeting with the therapist. Due to spatial constraints, and to honor the next child and his/her family, we try to limit extended time before and after sessions. We also ask that you please watch your children who are not directly in therapy closely as there are many items and pieces of equipment that can be enticing, but not

safe nor appropriate for free play when not with therapists. If your child does manage to find therapy toys or accident cause a spill, we are appreciative of your assistance to clean it up as best you can as it may go unnoticed initially due to our attention being on the current child in treatment.

Initials _____

Billing:

We are very understanding if your family's finances become an area of concern. Our priority is always the wellbeing of your child. Please communicate with us promptly if you foresee any issue with your insurance or other payment methods. You must also notify us if you believe your child's insurance will be changing or has changed as we must receive re-authorization to continue treating your child. Failing to pay invoices without appropriate communication with Kristen A. E. Bohan Inc., will subject you to collection processes. The fees incurred by these processes, legal and otherwise, will be added to your invoice.

Initials _____

I have read and understand the above information.

_____
Patient's Name

_____
Parent / Guardian Name

_____ _____
Parent / Guardian Signature Date

Notification of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Introduction

We are required by law to maintain the privacy of "protected health information". Protected health information includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care. This notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosure we will make of your protected health information. We will comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices upon request.

Permitted Uses and Disclosures

Once you give your written consent to your care and treatment, we can use or disclose your protected health information for purposes of treatment, payment and health care operations. If you refuse to consent, we do not have to provide you with care of treatment.

> Treatment means the provision, coordination or management of your health care, including consultations among your health care providers, including this office regarding your care and treatment.
> Payment means activities we undertake to obtain reimbursement for the services provided to you, including determinations of eligibility and coverage and other utilization review activities.
> Healthcare operations means the support functions of this practice related to treatment and payment, such as quality assurance activities, employee review activities, training of personnel, licensing, marketing and conducting or arranging for other business activities, receiving and responding to patient complaints, compliance programs, audits, business planning, development, management and administrative activities.

Other Permitted and Required Uses and Disclosures

We may use or disclose your protected health information in the following situations without your consent, authorization, or opportunity to object. These situations include:

Required By Law: We may use of disclose your protected health information to the extent that the use of disclosure is required by law. The use of disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses of disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information is we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Other Uses and Disclosures of Protected Health Information

We may contact you to provide appointment reminders or information about your care and treatment. We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. If you, or a responsible person, are available, we will give you or such person an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is

directly relevant to their involvement in your care. When permitted by law, we may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

We will allow your family and friends to act on your behalf to pick up reports, images, and similar forms of protected health information, when we determine, in our judgment, that it is in your best interest to make such disclosures.

Except for the special situations set forth below, we will not use or disclose your protected health information for any other purpose unless you provide written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

Your Rights

You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request.

You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.

Subject to payment of a reasonable copying charge, you have the right to inspect and copy the protected health information contained in your medial and billing records and in any other records used by us, except for:

a. information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

b. if the protected health information was obtained from someone other than us under a promise of confidentiality and the access requested be reasonably likely to reveal the source of the information.

We may also deny a request for access to protected health information if:

a. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person;

b. The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

c. The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

You have the right to request a correction to your protected health information, but we may deny your request for correction, if we determine that the protected health information or records that is the subject of the request:

a. was not created by us;
b. is not part of your medical or billing records;
c. is not available for inspection as set forth above; or
d. is accurate and complete.

In any event, any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

You have the right to request and receive a paper copy of this notice from us.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying Kristen Bohan of your complaint. There will be no retaliation against you for filing a complaint.

_____

Patient's Printed Name

_____ _____

Parent / Guardian Signature Date

Authorization of Video and Photo Release

I authorize Kristen A.E. Bohan, Inc. to record photographic and video media of my child and/or myself for the following purposes:

Reinforcement and encouragement for my child

Education and feedback of session content to parents and caregivers

Establishing home program routines

Use as a teaching tool for fellow students, parents, teachers and other professionals

Contribute to Kristen A.E. Bohan marketing or website

Specific names of anyone in photos or video clips will not be disclosed.

_____

Patient's Name

_____

Parent / Guardian's Name

_____ _____

Parent / Guardian's Signature Date

Notification of Medicaid Policies

The policies within this notice are directly from 59G-1.050 and applies to all Florida Medicaid recipients.

Providers may seek reimbursement from a recipient under the following circumstances:

a. The recipient is not eligible for Florida Medicaid on the date of service
b. The service rendered is not covered by Florida Medicaid, if the provider seeks reimbursement from all patients for the specific service
c. The provider verifies that the recipient has exceeded the Florida Medicaid coverage
d. The recipient is enrolled in a Florida Medicaid managed care plan (plan) and is informed that:
    i. The plan denies authorization for the service
    ii. The treating provider is not in the plan's provider network (with the exception of emergency services)

Patients must pay for services not covered by Medicaid. Our therapists and office staff will answer any questions you have about service coverage.

I have read and understand the above information.

_____
Patient's Name

_____
Parent / Guardian Name

_____ _____
Parent / Guardian Signature Date

Authorization For Credit Card Use

I permit and authorize Kristen A. E. Bohan, Inc. to keep my credit card information and signature on file. I authorize the charging of my credit card for all fees for products and services incurred by the patient, named below, both now and in the future. I understand a 5% charge will be added to the total to cover processing and software costs associated with accepting credit card payments.

Patient Name: _____

Patient DOB: _____

Cardholder Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Card Type:

☉ Visa ☐ Mastercard ☐ Discover ☐ Other:_____

Card Number: _____

Expiration Date: _____ CVV: _____

Cardholder Signature: _____ Date: _____