# Intake Information and Medical History

Child's Name:________________________________________ DOB:__________________________

Person completing this form and relationship to child:____________________________________

Please complete this form to the best of your knowledge. If you do not remember, please state "unknown".

## A. Reason for Referral

- Who referred you for services?:________________________________________________
- Does your child have a diagnosis? If so, when and from who?: __________________________
  ____________________________________________________________________________
- Current Functional Concerns: _____________________________________________________
  ____________________________________________________________________________
- Therapy Goals- Please write downt he 5 goals related to the above concerns that are currently most important for your child and family to work on during therapy sessions.
  1.
  2.
  3.
  4.
  5.

## B. Birth History:

- Was your child adopted? YES/ NO
  - (If yes and birth history is unknown, please skip to current medical information on page 2)
- Prenatal care received: YES / NO / UNKNOWN
- Was your child born full term? YES / NO
  - If no, what was the length of pregnancy in weeks? __________________________
- Pregnancy proceeded WITH / WITHOUT complications.
  - If complications were present, please list:
    ____________________________________________________________________
    ____________________________________________________________________
- Birth hospital:____________________________________________________
- Delivery proceeded WITH / WITHOUT complications
  - If complications were present, please list additional care that was needed:
    ____________________________________________________________________
    ____________________________________________________________________
- Delivery was VAGINAL / C-SECTION / EMERGENCY C-SECTION
- Birth weight:____________________ Birth height:____________________

- Was the baby discharged home with mom? YES / NO
    - If no: please explain:

      ______________________________________________
- Did the baby need to be transferred to another hospital for additional care? YES / NO
- Additional details of birth (please explain): (NICU, jaundice, etc):

  ______________________________________________

  ______________________________________________
- Was your child Breastfed? YES/ NO
    - If yes- for how long? ______________________

C. **Current Medical Information:**

- Does your child have a specific diagnosis and/or suspected diagnosis? YES / NO
    - If yes, please explain:

      ______________________________________________

      ______________________________________________
- Who is the doctor that provided this diagnosis? ______________________
- Is the child still under this doctor's care? YES / NO
- Current Medications: (Please list dosage and frequency):

  ______________________________________________

  ______________________________________________
- Current vitamins, supplements, herbs, and/or homeopathic remedies? Please list dose, frequency and usage: ______________________

  ______________________________________________
- Please list ALL allergies and sensitivities:

  ______________________________________________

  ______________________________________________
- Does your child require an EPI-Pen YES / NO
    - If yes, please be sure to complete our EPI-PEN form.
- Has your child's ***HEARING*** ever been tested? YES / NO
    - If so, what were the results within normal limits? YES /NO
    - Does your child have PE tubes? YES / NO / PREVIOUSLY
    - Does your child have frequent ear infections? YES / NO / Previously
    - If yes, please explain:

      ______________________________________________
    - Do you have any concerns regarding your child's hearing? YES / NO
- Has your child's ***VISION*** ever been tested? YES / NO
    - If so, what were the results within normal limits? YES /NO
    - If no, please explain:______________________
    - Does your child wear glasses? YES / NO

   - If yes, do they need to wear them full time? Please explain:
     ______________________________
   - Do you have any concerns regarding your child's vision? YES / NO
- Please list *ALL on-going specialists* and services your child *currently receives* including frequency of visits (outside of school). This may include but not limited to: neurologist, cardiologist, psychologist, chiropractor, homeopathic practitioner, physical therapy, etc:
  ______________________________
  ______________________________
  ______________________________
- Has your child ever been hospitalized or had any major illness? YES / NO
   - If yes, please explain:
     ______________________________
     ______________________________
- Has your child undergone any surgeries? YES / NO
   - If yes, please explain:
     ______________________________
     ______________________________
- Has your child received any medical tests such as MRI, EEG, etc that may be pertinent to his/her treatment here? YES / NO
   - If yes, please explain:
     ______________________________
     ______________________________

## D. Developmental History

- When did your child meet the following developmental milestones:
   - Rolling: ______________________________
   - Sitting up: ______________________________
   - Crawling: ______________________________
   - Walking: ______________________________
   - Other milestone concerns:
     ______________________________
- What hand is used most often for utensil use?   RIGHT / LEFT / UNDETERMINED
- If age-appropriate, do you have concerns regarding handwriting?  YES / NO / PREVIOUSLY
   - If yes, please explain: ______________________________
     ______________________________

**E. Description of child:**

- Please describe your child's strengths:

  ______________________________________________

  ______________________________________________

- What are your child's favorite toys and activities?

  ______________________________________________

Child's Demeanor:

(Please **check** ✓all that apply)

- ☐ Active
- ☐ Affectionate
- ☐ Aggressive
- ☐ Calm
- ☐ Cautious
- ☐ Curious
- ☐ Demanding
- ☐ Difficult to comfort
- ☐ Distractible
- ☐ Fearful
- ☐ Fearless
- ☐ Fussy
- ☐ Insecure
- ☐ Motivated
- ☐ Passive
- ☐ Persistent
- ☐ Playful
- ☐ Shy
- ☐ Stubborn
- ☐ Withdrawn
- ☐ Other: Please explain:______________________________________________

Therapeutic Links
PEDIATRIC OCCUPATIONAL THERAPY

**F. Child's Sensory Processing Checklist**

(Please **check** ✓all that apply; Put **P** if previously seen)

- ☐ Avoids getting messy
- ☐ Seeks out (craves) touch/ tactile stimulation
- ☐ Seeks out movement
- ☐ Stumbles or falls frequently
- ☐ Appears awkward or less coordinated
- ☐ Flaps arms
- ☐ Does not allow brushing of teeth
- ☐ chews/sucks on non-food items frequently
- ☐ Lines toys up/ limited play skills
- ☐ Bangs head, hit surfaces, hits others frequently
- ☐ Fatigues quickly
- ☐ Sedentary
- ☐ Resists certain environments
- ☐ Spins things or self frequently
- ☐ Has self-abusive behaviors
- ☐ Is sensitive to noises or sounds
- ☐ Is sensitive to lights
- ☐ Sleeps more than typical
- ☐ Resists touch or being held/hugged
- ☐ Seeks intense hugs/deep pressure from others
- ☐ Walks on toes
- ☐ Seeks out visually-stimulating objects
- ☐ Seeks out stimulating sounds
- ☐ Enjoys music
- ☐ Resists certain movements. Please list: ________________________________
- ☐ Has difficulty figuring out how to move his/her body
- ☐ Does not tolerate certain textures. Please list: ______________________________
- ☐ Has difficulty with transitions
- ☐ Has difficulty falling asleep
- ☐ Has difficulty staying asleep
- ☐ Has poor sense of body in space(leans on furniture or people and/or runs into things)
- ☐ Demonstrates rigid or still movement patterns
- ☐ Hyper-focused on specific items, tasks, people, toys, etc
- ☐ Other (please explain):

______________________________________________________________________________

How does your child self-calm? ____________________________________________________

______________________________________________________________________________

## G. **Social Emotional Skills:**

(Please **check** ✓all that apply)

- ☐ Is easily distracted
- ☐ Calms self easily
- ☐ Gets angry or frustrated easily
- ☐ Is aggressive towards others
- ☐ Prone to emotional outbursts
- ☐ Doesn't allow others to join in play
- ☐ Plays easily with peers
- ☐ Makes friends easily
- ☐ Does not have very many known friends
- ☐ Only likes to play with adults or older peers
- ☐ Prefers to play alone
- ☐ Has difficulty with separations
- ☐ Poor eye contact
- ☐ Difficulty with communication of wants and needs
- ☐ Other: Please explain:________________________________________

## H. Oral-Motor Skills

- Does your child have any feeding problems or difficulties: YES / NO
  - If yes, please explain:
    ____________________________________________________________
- Is your child a picky eater? YES / NO
  - If yes, please list *preferred* foods:
    ____________________________________________________________
    ____________________________________________________________
  - Please list *non-preferred* foods:
    ____________________________________________________________
    ____________________________________________________________
- Do you have any concerns regarding Speech? YES / NO
  - If yes, please explain:
    ____________________________________________________________
- Does your child receive private speech services? YES / NO / PREVIOUSLY
  - If yes, please state frequency and location:
    ____________________________________________________________

**I. Child's Home Environment, Work and Leisure:**

- Who does your child live with? ______________________________________________
  ____________________________________________________________________
- Please list any extracurricular activities your child participates in: __________________
  ____________________________________________________________________
- Does your child have or are you in need of any adapted equipment and/or assistive devices/ technology? YES / NO / UNSURE
  - If yes, please explain:______________________________________________
- If age appropriate, does your child participate in chores around the house? YES / NO
  - If yes, please explain:______________________________________________
- If age appropriate does your child perform activities of daily living with minimal to no assistance? These activities include but not limited to: waking up in the morning, getting dressed/undressed, brushing teeth, taking a bath/shower, dressing for weather, feeding self and/or preparing simple meals etc. YES / NO
  - If no, please explain areas of difficulty: ______________________________________
    ____________________________________________________________

**J. Educational history:**

- Name of school: ________________________________________ Grade: ____________
- Does your child have an IEP? YES/NO 504 Plan?: YES/NO
- Please list all special education services is your child receiving at school:
  ____________________________________________________________________
  ____________________________________________________________________
- Would you like Therapeutic Links to communicate with your child's school? YES / NO
  - If yes, please provide contact information and please make sure your school has an authorization to speak to us. (Please provide us any school IEP/ 504 plans in order to assist with our communication with the school, as well as please complete our consent release)

Any additional comments and/or information, please list and explain below:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

## Primary Reflex Movement Patterns Checklist

**Based on the work of Dr. Svetlana Masgutova. MNRI**

Name: ___________________________________ Date of Birth ____________
Today's Date: ___________________
Completed by: _______________________________________________________

**Please place a check by those characteristics you observe with your child. Please add comments or additional concerns.**

### Muscle Tone

___ Difficulty achieving and maintaining stability in sitting , standing, and during movement
___ Frequently "W" sits
___ Joints present as tight ___ limbs lack mobility
___ Joints are extremely flexible ___ Limbs are hyper mobile
___ Muscle tone appears typical to peers
___ Seeks sedentary play
___ Difficulty grading movement actions
___ Tends to seek support when sitting or standing
___ Tends to be fixed or erect

Comments:

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### Hands Grasp

___ Difficulty dressing self (without fasteners) including socks/shoes due to lack of hand strength to pinch and pull up
___ Difficulty picking up small items
___ Difficulty with fasteners ___ Buttons ___ Snaps ___ Zippers
___ Difficulty tying shoes
___ Inefficient grasp of writing tools (pencil/pen) ___ excessive pressure ___ looses grasp
___ Poor handwriting
___ Breaks Pencils often
___ Difficulty with school tool use for ___ coloring ___ cutting ___ drawing ___ gluing
___ Inefficient grasp of scissors
___ Inefficient grasp of eating utensils ___ spoon ___ fork ___ knife ___ excessive pressure ___ too light of pressure
___ Prefers to eat with fingers
___ Able to spread toppings with a knife ___ yes ___ no
___ Poor speech and communication
___ Poor written expression

Comments

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### Hands Pulling

___ Poor socialization; giving and taking
___ Difficulty with ball skills
___ Occulomotor control challenges (convergence and divergence)
___ Difficulty with eye hand coordination activities
___ Difficulty with bilateral hand skills ___ buckling pants/belt ___ putting on pants or a belt ____ buckling seat belt ___ pouring liquids ____ difficulty with snaps

___ Difficulty climbing
___ Difficulty brushing teeth
___ Difficulty self feeding with utensils
___ Difficulty picking up small items
___ Difficulty lifting, pushing, pulling heavy objects
___ Head righting and vestibular issues
___ Poorly regulated muscle tone in the arms
___ Poor fine motor coordination, difficulty with handwriting
___ Speech and communication delays

Comments:

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**Hands Supporting**

___ Frequent injuries with falls (does not put hands out to protect self)
___ Lack of arm, hand, eye coordination
___ Lack of body and space awareness/boundaries
___ Poor safety awareness
___ Poor social boundaries (aggressive, standoffish, isolated, easily becoming a victim, bully or being bullied)

Comments

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**Babkin**

___ Associated oral reactions with hand utilization; i.e. Tongue movements, lip movements or tightening of the lips
___ Biting clothing or objects
___ Clenched fists
___ Eating challenges
___ Nail biting
___ Digestive issues
___ Difficulty blowing nose to clear

Comments

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**Babinski**

___ Always on the go fidgety
___ Poor balance ___ poor balance on uneven surfaces ___ trips easily ___ presents as clumsy
___ Poor lower body coordination ___ poor galloping ___ poor jumping jacks ___ poor skipping ___ poor running
___ Poor gait pattern ____ walks on inside of feet ___ walks on the outside of feet ___ walks on toes ____ walks with toes inward ___ walks with toes outward ___ flat arches
___ Hip and knee problems
___ Unable to stand still; lacks grounding and stability
___ Issues with feet ____ socks have to be just right ____ prefers to go barefoot
___ Oral motor issues ___ bites or chews objects/clothing ___ difficulty using a straw ___ drools ___ grinds teeth ___ does not notice a mess on face when eating

## Spinal Pereze

___ Leans on people/objects for stability
___ Poor differentiation of pelvis from spine
___ Low back tends to be stuck in extension
___ Unable to assume super man position on their belly
___ Delayed crawling in developmental history
___ Delayed walking in developmental history
___ Atypical walking pattern ___ stiff ___ lacks reciprocal arm movement ___ waddles ___ leans forward
___ Spinal deformities
___ Tactile hypersensitivity
___ Auditory hypersensitivity
___ Short and long term memory difficulties
___ Plays roughly with people and objects
___ Has difficulty grading their actions; too fast/slow, too hard/soft
___ Bladder issues ___ bed wetting ____ potty training
___ Complains of stomach pains
___ Picky eater
___ Breath holding with effort

Comments

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## Spinal Gallant

___ Deficits in auditory processing
___ Discomfort with tight fitting clothes
___ Hyperactivity
___ Enuresis, incontinence, irritable bowel syndrome
___ Abnormal gait with incorrect hip rotation
___ Poor concentration
___ Poor gross motor coordination
___ Scoliosis
___ Tendency to adjust body/forget frequently when sitting in a chair
___ Falls out of their chair

Comments

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## Trunk Extension

___ Posture tends to bend forward or backwards; don't seem to have midline
___ Tendency to toe walk
___ Difficulty pushing up on toes and coming back down as when needing to reach something that is high up
___ Over focused on details, missing the big picture; "can't see the elephant in the room"
___ Emotional or irrational issues; talks without making emotional connections
___ Limited imagination
___ Timing of jumping is not there
___ Leans against external supports when sitting or standing

Comments:

___ Issues with fine motor coordination
___ Difficulties with gross motor coordination
___ Language delays
___ Timidity
___ Poor crawling patterns

Comments

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**Foot Tendon Guard**

___Difficulty standing; poor grounding and stability
___ Uneven support of body weight on foot arches
___ Poor coordination for ___ climbing ___ jumping ___ running ___ swimming
___ Emotional instability and lack of self confidence
___ Lack of ability to adapt for focus and change perspective, rigidity in thinking
___ Lack of flexibility
___ Lack of positive self protection
___ Difficulty letting go of stress and fears
___ Poor walking patterns: ___ unable to walk a straight line, ___ loses focus in walking ___ unable to use a heel toe gait
___ Delay in articulation and speech development
___ Poor motor memory and lack of self confidence in making choices

Comments

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**Leg Cross Flexion Extension**

___ Difficulty balancing on one leg; balances on left foot for ___ seconds, balances on right foot for ___ seconds
___ Difficulty coordinating legs to ride a bicycle
___ Hesitant when descending/climbing stairs
___ Hyperactivity
___ Poor coordination across the body midline/ poor ability to cross crawl, to cross body midline
___ Postural problems in general

Comments

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**Bauer Crawling**

___ Asymmetrical gait pattern
___ Poor orientation in space
___ Poorly developed perspective vision
___ Slow study pace

Comments

STNR

___ Visual issues ___ wears glasses ___ difficulty visually tracking ___ poor eye contact ___ keeps eyes close to paper ___ poor visual monitoring of hand during fine motor tasks ___ difficulty finding objects in competing backgrounds
___ Difficulty moving hands, arms, head separately; tends to move as one unit
___ Reactivity between head and muscles of the arms: head down arms flex/heads up arms extend
___ Puts head down excessively ___ when drawing ___ when reading ___ writing
___ Prefers to stand to engage in hand activities
___ Poor balance, spatial or temporal awareness
___ Prefers sedentary play
___ Problems with athletics/avoids new physical challenges
___ Social issues; underachievement, frustration, avoidance

Comments

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ATNR

___ Difficulty following verbal directions
___ Frequently asks for repetition of directions: Says "what" a lot
___ Slowed or delayed responses to auditory information
___ Frequently misunderstands
___ Does not consistently respond to their name
___ Difficulty sequencing events
___ Difficulty with attention, focus, and memory
___ Imbalance between focus and peripheral vision; does not get the big picture, focus tied to arms length
___ Disorganized approach to self care tasks/routines ___ brushing teeth ___ preparing simple food ___ getting dressed
___ Letter and number reversals
___ Preferred hand is undetermined ___ Preferred hand is left ___ Preferred hand is right
___ Uncoordinated cross lateral movement: difficulty turning/rotating/twisting
___ Does not care for puzzles

Comments

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Moro

___ Becomes overly excited after movement activities
___ Seeks intense movement experiences
___ Motion sickness
___ Thrill seeker with little regard for safety
___ Respiratory issues ___ Breath holding with effort ___ Breath holding without effort ___ Rarely yawns ___ Yawns excessively/frequently ___ Shallow breath pattern. ___ Mouth breather
___ Sleep issues ___ difficulty falling asleep ___ difficulty staying asleep ___ difficulties waking up
___ Excessive anxiety ___ timidity ___ maladaptive patterns of self protection ___ lack of trust
___ Fear of taking risks required for learning
___ Fearful of feet leaving the ground when in control of the activity
___ Fearful of feel leaving the ground when out of control of the activity
___ Hypersensitivity to vestibular stimulation; does not like his head tipped back
___ Motion sickness

**Flying and Landing**

___ Phobias of heights
___ Gravitational insecurity: does not like their feet to leave the ground
___ Unable to jump efficiently
___ Impulsive jumping; jump all the time
___ Challenged to judge height and depth
___ Lacks control in dangerous situations

Comments:

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**Automatic Gait**

___ Asymmetry (uneven) in walking
___ Poor spatial orientation
___ Tendency to pace back and forth
___ Slower study pace
___ Difficulty taking in the big picture, distance visual perspective

Comments

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**TLR**

___ Poor sequencing skills: challenges with space and time
___ Poor cause and effect awareness
___ Gets car sick: vestibular problems
___ Did not crawl as an infant
___ Locks legs in standing to maintain posture
___ Hyper muscle tone
___ Hypo muscle tone
___ Avoids sports
___ Trouble throwing a ball
___ Tends to slide our of their chair and under the table or desk
___ Seeks head banging
___ Visual issues with focus and tracking

Comments:

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**Landau**

___ Poor muscle tone
___ Difficulty concentrating
___ Clumsy in movements
___ Stands with locked knees
___ Hard to understand new things

Comments:

___ Poor adaptability
___ Poor balance
___ Problems with choice making
___ Weakened Immune system

Comments

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**Fear Paralysis**

___ Hypersensitivity or excessive reaction to ___ touch stimuli ___ visual stimuli ___ auditory stimuli
___ Overly sensitive to loud noises
___ Overly sensitive to visual stimuli
___ Dislikes having their vision occluded
___ Difficulty completing tasks when sounds are nearby
___ Hears sounds that others do not hear
___ Excessive anxiety, timidity, maladaptive patterns of self protection, lack of trust
___ Fails to read visual cues in the environment
___ Holds body stiffly
___ Hyperactive gag responses
___ Hyperactivity in general
___ Resistive to grooming activities ___ brushing teeth ___ dentist ___ haircuts ___ nail trimming
___ Visual distracted
___ Difficulty with ball skills

Comments

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Your Child's Strengths:

Your Child's Challenges:

What would you like for your child?

Compiled by Mary T Wirth MS, OTR.L, C.NDT, MNRI Core Specialist and Instructor
Please use as it supports your MNRI practice, free to copy, adapt, and modify BUT always identify the checklist as based on the work of Dr Svetlana Masgutova.

Clinic: Grayslake, IL
Aquatic: Pleasant Prairie, WI/Grayslake ,IL
Home/Daycare/ School
847-548-3458 Clinic
847-548-3459 Fax
www.therapeuticlinks.com

## FINANCIAL POLICY

Thank you for choosing Therapeutic Links as your child's occupational therapy provider. We look forward to working closely with your child and your family. Please read the following statement regarding Therapeutic Links financial policy and procedures before beginning therapy services. Please ask us to clarify any part of this policy if you have questions.

**Fees:**

| | |
|---|---|
| Clinic visits: | $150/hour |
| Home visits: | $150/hour (unless otherwise discussed in regards to distance traveled) |
| Aquatic Therapy: | $180/hour |
| Initial Evaluation: | $312.50 |
| Non-Insurance rate: | Eval: $218.75 Visit: $105/hour |
| Groups: | Available at varying rates due to therapist-client ratio and duration |
| Early Intervention services: | Determined by the Early Intervention Program in Illinois. |

**Payment:**
Therapeutic Links produces and emails invoices on the 15th and last day of each month. Payment is due 30 days following. On occasion that a payment is 60 days delinquent your credit card will be billed. A current credit card number and signature must remain on file at all times. Please refer to the *Credit Card Information Form.* Copays are due at the time of service. Your family is responsible for all claims that go towards your deductible. Services will be put on hold when the account balance reaches $500 and 30-days past due and/or if copays are not received at the time of service for two consecutive weeks.

**Payment options:**
You are welcome to pay by check or credit card (Visa and MasterCard). If you answer "yes" to being billed by credit card your credit card will automatically be billed for services rendered unless otherwise discussed. If you prefer to pay by check please write the account number. This will avoid confusion regarding dates paid.

**Insurance:**
Having an insurance plan does not guarantee coverage for our services. Therapeutic Links is part of the BCBS PPO Networks. Once your insurance company has paid its share, you will be responsible for any remaining balance.

___ (initial) **If your insurance company declines coverage for services, you will be responsible for the full balance.**

If payment is not received from your insurance within 60 days, your credit card will be charged. If Therapeutic Links receives payment from your insurance after this time, a refund to your credit card will be issued.

___ (initial) **You are responsible for knowing the requirements of your policy including referrals, co-payments, pre-certification etc. If you do not meet these requirements, and/or we are not contracted with your insurance company, you will be responsible for the entire fee.**

If on-going services are denied, Therapeutic Links will support your appeal by means of Letters of Medical Necessity and communication with the insurance company when additional clinical information is requested.

**Missed Appointments:**
Please call to cancel an appointment at least 24 hours in advance. Therapeutic Links reserves the right to charge for missed appointments without advanced notice. Late arrival to appointments will be brought to your attention and discussed in regards to payment due to you without the possibility of insurance reimbursement for the part of the session that was missed. The remainder of the session in which the child is seen for therapy will be insurance reimbursable. Cancellations due to illness or emergency are exceptions. Please plan on canceling if your child is sick including the following: Fever within 24 hours of appointment, green runny nose, continuous cough, contagious infection (Pink eye, strep, etc.) and/or close contact or positive test of COVID-19.

I, the undersigned, assume financial responsibility as stated above. I have read, understand, and agree to this Financial Policy. I have informed all legal guardians of this child and responsible parties for the above and have been given permission to be a representative in reading, understanding, agreeing to and signing this document. My social security number is provided as a means for my financial obligation for payment services provided.

______________________________(**Social Security** of parent/financial party)

______________________________(Signature of parent/financial party) ____________(Date)

Last Updated on: 01/12/21
*Financial policy is subject to change without notice.

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# CREDIT CARD INFORMATION

Child's name:__________________________ Date:___________________

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage to both you and the hotel or rent company, since it makes checkout easier, faster, and more efficient.

We utilize a similar policy. You will be asked for a credit card number at the time you register and that information will be held securely with our billing department. Once the insurance(s) have paid their portion they will notify us of the amount you owe. All balances will be provided to you via your Fusion Portal and if you contact our office.

I understand the following: (Please Initial)
____(Initial) A current credit card number and signature MUST remain on file at Therapeutic Links, PC at all times.
____(Initial) I understand that I can log onto my Fusion portal to check balances due.
____(Initial) **If a bill is *delinquent* past 60 days,Therapeutic Links, PC will *automatically* bill my credit card for the total amount due.**

Please CHECK ONE of the following options:
___1) I authorize Therapeutic Links, PC to AUTOMATICALLY charge the listed credit card for each billing period as indicated on each invoice or indicated by insurance EOB in regards to copayment or balance due.
___2) BEFORE transactions are processed using this credit card, I will provide verbal and/or written authorization of payment options within 24 hours of request to Therapeutic Links, PC. In this option, I understand that therapies may be on hold if my bill is upwards of $500.

Credit Card (circle one): Visa Mastercard

Credit Card Number:________________________________________________________

Expiration (month/year):______________________3-digit code on back ___________________

Name as it appears on the credit card:____________________________________________

Authorized Signature:________________________________________________________

Billing Zip Code:_______________________________

Credit Card Billing Address if different from home address:_________________________________

I have read and understand this Credit Card Form. I have also signed the **Financial Policy**. I understand the policy in regards to fees, payment, payment options, insurance and missed appointments through Therapeutic Links, PC. I understand that I am responsible for payment of services rendered.

______________________________ _________________
Signature Date

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## INSURANCE INFORMATION

1. Complete the INSURANCE INFORMATION worksheet(s) for each policy or plan that covers your child. Additional identifying information may be requested to assist with the verification and/or reimbursement from outside sources.
2. A clear copy of the insurance card(s) (front and back) must also be provided.

____ (Please Initial) **It is the family's responsibility to review and/or contact your health care plan to determine coverage for services. In addition, we will contact your health plan for a verification of benefits prior to beginning services. Verification of benefits and/or additional information provided does not guarantee payment by the insurance provider and therefore the family (or other stated responsible party) is finally responsible for any charges incurred.**

ALL FAMILIES ARE RESPONSIBLE FOR PROVIDING INFORMATION REGARDING ANY CHANGES IN INSURANCE STATUS. FAILURE TO REPORT THESE CHANGES MAY RESULT IN FINANCIAL RESPONSIBILITY OF THE BALANCE FROM THE FAMILY AND/OR DISCONTINUATION OF SERVICES TO ENSURE APPROPRIATE REIMBURSEMENT.

Child's Full Name: ______________________ Date of Birth: ________________ Diagnosis: __________

Parent's Name (s): ____________________________________ Home Phone: ______________

Address: ________________________________________________________________

### INSURANCE OR BENEFIT PLAN INFORMATION

Name of Insurance Company/Plan: ______________________________________

ID Number: ___________________________ Group: ____________________

Provider Services Phone Number (on back of card): ____________________________

Name of Policy Holder: ____________________ Date of Birth: ________________

List additional insurance contract information or other insurance related information: ________________

________________________________________________________________

___I allow Therapeutic Links to file claims for and in consideration of the provision of services via the 1500 HICA form. I hereby assign, transfer, and set over my rights and interests in insurance benefits for the services rendered. I hereby authorize all payments to be made directly to and will turn over any payments made to me for services rendered by the above. All claims to Blue Cross Blue Shield PPO must be submitted by our offices in accordance to the preferred provider contract.

___I do not intend to file any claims to health insurance. I understand a discount will be reflected on my invoice.

I certify that the information given above is correct to the best of my knowledge. I also understand that I am responsible for providing any changes to the status of my child's insurance coverage or will be financially responsible for the balance and may have a discontinuation in services.

I understand verification of insurance benefits and/or submission of invoices and/or supporting documentation does not guarantee payment by the insurance provider and the family (or other stated responsible party) is financially responsible for any charges incurred.

PARENT OR GUARDIAN SIGNATURE: ______________________________ DATE: ______________

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# CONSENT FORM

1. **Consent for Treatment** _____(parent initials) Child's name:_______________________________________________

I hereby give permission for my child to be treated by Therapeutic Links for therapy services. Therapy services have been explained to me and I understand this treatment and explanation and approve of said treatment. I understand that I need my child's doctor to write out a prescription for occupational therapy services before I start services and every year thereafter. I hereby authorize Therapeutic Link, P.C. and its personnel to supervise and instruct my child in all therapeutic activities. I realize that with participation in occupational therapy involving physical activities there may be the possibility of injury for which I currently have medial or student accident coverage. I give permission to Therapeutic Links P.C. to secure medical and/or emergency treatment for my child while in their care. This may include, but is not limited to, first aid care by a physician, paramedic or local hospital.

Emergency Contact Name and Number: ____________________Preferred Hospital/ER: ______________________________

Physician Name and Number: ___________________________Dentist Name and Number: __________________________

**AUTHORIZED PERSONS TO WHOM CHILD MAY BE RELEASED:**

| Name | Address | Phone | Relationship |
|---|---|---|---|
| | | | |
| | | | |

2. **Video/Picture Release:** **Please mark the descriptions you are approving with your initials.**

**I give permission for my child's picture/video to be used by Therapeutic Links, P.C. for the purpose :**

______ of training and collaborating with other (para) professionals.

______ of professional presentations

______ marketing/publicity (i.e. posters, website, flyers, social media, etc.)

______ I **DO NOT** give permission for my child's picture/video to be used for any purpose other than training his/her clinical team.

3. **Dietary Information/Food Release:** **Please mark the appropriate description with your initials.**

**My child may participate in snack time**:

_____ and has no diet restrictions.

_____ as long as the following diet restrictions are observed.

*Please list diet restrictions:* ______________________________________________

_____ however, his/her snack will be provided from home.

_____ **I DO NOT** authorize my child to participate in snack/food related activities

4. **Epi-Pen:** My child requires an EpiPen on site. (Please see other form)** ____________________________

5. **Off-Site Release**

Your initials give Therapeutic Links, P.C. consent for your child to participate in therapeutic activities outside of the clinic when accompanied by a staff member in the indicated locations. Outside activities will occur when weather is appropriate and the child is wearing appropriate clothing. Proper protective gear is available for biking, rollerblading and scooter riding when not supplied from home. In addition, attempts to gain verbal permission prior to each activity will occur if the parent is present at the clinic. Please let us know if other precautions should be taken.

_____ Grass and/or pavement immediately outside clinic _____ Predetermined community outings

_____ Park located in neighborhood West of the clinic _____ Other: ___________________________

6. **Weather Precautions**

_____ I give Therapeutic Links, P.C. permission to apply sunscreen and/or insect repellent on my child when participating outdoors

_____ I **DO NOT** give permission for the application of sunscreen and/or insect repellent

7. **Restroom Policies**

_____ I give Therapeutic Links, P.C., its therapists and staff members permission to assist my child with restroom activities, including but not limited to restroom sequences and/or hygiene activities.

8. **Telephone Consent:** I give my permission for information regarding my child, his/her account, and/or scheduling to be communicated: _____ Email (email address: ________________________________)

_____ via text messaging (cell phone: ____________________________)

I understand the terms of the video, dietary/food and park/outside release information.

______________________________________________________________________

Parent/Guardian Signature(s) Date

1/18/21

Clinic: Grayslake, IL
Aquatic: Pleasant Prairie, WI/Grayslake ,IL
Home/Daycare/ School
847-548-3458 Clinic
847-548-3459 Fax
www.therapeuticlinks.com

## Consent for Release of Information

Collaboration with other professionals is crucial to developing a successful program for your child. Please list all professionals in which you would like to include as part of your child's comprehensive team. This list may include but is not limited to the following: therapists (speech, physical, occupational), doctors, schools, teachers, insurance company, lawyers, relatives, insurance advocates and any other people or institutions that may need information about your child's occupational therapy records.

**I, ________________________________(Parent or Guardian of Patient) authorize Therapeutic Links, P.C. to provide those listed below with any information requested regarding the occupational therapy services for ______________________ (Patient's Name). This information may include but is not limited to written documentation, financial records, demographic data and billing records of patient.**

1.____________________________________________________________

Name | Title/Relation to child | Phone Number | Date added/ Parent Initial

2.____________________________________________________________

3.____________________________________________________________

4.____________________________________________________________

5.____________________________________________________________

6.____________________________________________________________

7.____________________________________________________________

______ (Please Initial) I have seen and understand the copy of The Federal HIPAA Laws

____________________________________________________________

Parent or Guardian signature(s) Date

A photocopy of this form is authorized to serve the same as original.

1/18/21

998 Progress Drive
Grayslake, IL 60030
www.therapeuticlinks.com
847-548-3458
847-548-3459 fax

**HIPAA Information and Consent Form**

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April, 14 2013. Many of the policies have been *our* practice for years.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for handling of charts, patient records, PHI, and other documents or information.
2. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
4. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager.
5. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
6. We agree to provide patients with access to their records in accordance with the state and federal laws.
7. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and patient.
8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.