Little Hands

INSTRUCTIONS

Occupational Therapy Intake

Please save this PDF on your computer, fill out with your computer/keyboard (no handwritten responses please), save, and email the filled out PDF form to gp@littlehandsot.com.

IMPORTANT: This completed intake form and payment of the invoice related to your upcoming evaluation are required at least 1 week prior to your child's scheduled assessment date. If payment is not received within 72 hours of your scheduled evaluation date we will be forced to cancel the evaluation.

Summary of Enclosed Documents

- Occupational Therapy Intake Form (pages 2 to 14) - **fill out**
- Practices & Policies (pages 15 to 18) - **fill out/authorize**
- Credit Card Authorization Form (page 19) - **fill out/authorize**
- Notice of Privacy Practices (page 20)

Questions?

Please call or email Gabrielle Perelmuter:

Phone: (415) 531-3027
Email: gp@littlehandsot.com

Little Hands
500 Tamal Plaza, Suite 527
Corte Madera, CA 94925
www.littlehandsot.com

Person Completing This Form

Full Name

Date

Relationship to Child

Child's Information

Child's Full Name

Referred By

Child's Nickname (if applicable)

Child's Date of Birth (mm/dd/year)

Child's Current Grade

Name of Child's Current School

Child lives with (check one)

- [ ] Both Parents
- [ ] Parent & Step-Parent
- [ ] One Parent
- [ ] Adoptive Parents
- [ ] Other:

Child's Siblings (if applicable - name/sex/age)

Food Allergies (if applicable)

Medications (if applicable)

Restricted Foods (if applicable)

Parent's Information

PARENT 1

Full Name

Occupation

Phone

Email Address

PARENT 2

Full Name

Occupation

Phone

Email Address

Billing Address Information

Street Address

City

State

Zip

Caregiver Information

(Nanny, family members, or others who may drop off/pick up child)

Caregiver Full Name

Caregiver Email Address

Caregiver Phone

Pediatrician Information

Pediatrician Full Name

Pediatrician Email Address

Pediatrician Phone

Clinician(s) Information

(Related to child's diagnosis or therapies)

Clinician 1 Full Name

Clinician 1 Email Address

Clinician 1 Phone

Clinician 2 Full Name

Clinician 2 Email Address

Clinician 2 Phone

Clinician 3 Full Name

Clinician 3 Email Address

Clinician 3 Phone

☐ **I authorize Little Hands to release and exchange information with all clinicians listed above.**

Background Information

Current Therapy Services (Include history of therapy - if applicable)

Current Diagnosis Related to Your Child (Include history of therapy - if applicable)

Primary Concerns & Goals

Why did you bring your child to Little Hands Occupational Therapy for an evaluation?

What occupational therapy goals do you have for your child?

Developmental History

1. How many weeks into the pregnancy was your child delivered?

2. What was your child's birth weight?y was your child delivered?

3. Were there any immediate concerns after the birth of your child?

☐ Yes ☐ No

If yes, please explain:

4. Were any difficulties encountered during the labor and/or delivery of your child?

☐ Yes ☐ No

If yes, please explain:

5. Describe your child's sleep patterns as an infant

6. Were there any weight gain or feeding issues when your child was a baby?

☐ Yes ☐ No

If yes, please explain:

7. Was your child difficult to console when agitated?

8. How would you describe your child's activity level as an infant?

Developmental Milestones

9. At what age did your child achieve the following gross motor milestones?

Sitting independently:

Crawling:

Walking:

10. At what age did your child establish language skills using:

One word:

Two words:

11. At what age did your child regularly use the toilet?

Please explain any delays):

Language and Auditory Processing

12. Does your child have difficulty articulating words? ☐ Yes ☐ No

13. Is your child able to follow a single-step direction after it is given? ☐ Yes ☐ No

14. Is your child able to follow a multi-step direction after it is given? ☐ Yes ☐ No

Gross Motor Skills

15. Does your child bump into people or objects while walking? ☐ Yes ☐ No

16. Does your child fall easily? ☐ Yes ☐ No

17. Does your child seem fearful of movement? ☐ Yes ☐ No

18. Can your child jump with both feet off the ground? ☐ Yes ☐ No

19. Does your child seem clumsy or uncoordinated? ☐ Yes ☐ No

20. Does your child have difficulty moving his or her body on playground equipment? ☐ Yes ☐ No

21. Does your child have difficulty pedaling when riding a bike? ☐ Yes ☐ No

22. Is your child able to balance on one foot? ☐ Yes ☐ No

23. Does your child have difficulty performing reciprocal movement patterns (e.g., alternating legs when climbing stairs)? ☐ Yes ☐ No

If yes, please explain:

Gross Motor Skills Checklist

Please indicate the amount of assistance your child needs to complete the following by placing a check in the corresponding box.

Skill	Unable	< 25% Independent	25% Independent	50% Independent	100% Independent
Jump with both feet					
Hop on one foot					
Skip					
Gallop					
Pump legs to swing					
Climb stairs alternating legs					

Gross Motor Skills Checklist *(Continued)*

Skill	Unable	< 25% Independent	25% Independent	50% Independent	100% Independent
Throw a ball					
Catch a ball					
Climb a play structure					
Rides a bike					

Fine Motor Skills and Activities of Daily Living

24. At what age did your child show hand preference?

25. Does your child appear to be right or left-handed?

☐ Right ☐ Left

26. Does your child draw using dark or light lines (e.g., faint or bold pencil marks)?

☐ Yes ☐ No

If yes, please explain:

27. Does your child have difficulty grasping and managing small objects?

☐ Yes ☐ No

28. Does your child have difficulty grasping a writing utensil?

☐ Yes ☐ No

29. Does your child have difficulty coordinating finger movements to use scissors?

☐ Yes ☐ No

30. Does your child participate in constructional activities (e.g., Legos, puzzles)?

☐ Yes ☐ No

If yes, please explain:

31. Does your child create drawings with recognizable parts?

☐ Yes ☐ No

If yes, how many?

32. Does your child have difficulty using both hands together to complete activities (e.g., stringing beads, managing zippers and buttons)?

☐ Yes ☐ No

If yes, please explain:

33. Does your child use his or her non-dominant hand to stabilize paper when cutting, writing and drawing?

☐ Yes ☐ No

If yes, how many?

34. Does your child have difficulty managing eating utensils (e.g., scooping food with a spoon, using a fork and knife together to cut)?

☐ Yes ☐ No

If yes, please explain:

35. Does your child dress himself or herself without help?

☐ Yes ☐ No

If no, does your child assist with dressing?

36. Does your child orient clothing appropriately when dressing and put on clothing the correct way?

☐ Yes ☐ No

37. Does your child have difficulty tying his or her shoes?

☐ Yes ☐ No

Self Help Checklist

Please indicate the amount of assistance your child needs to complete the following by placing a check in the corresponding box.

Skill	Unable	< 25% Independent	25% Independent	50% Independent	100% Independent
Takes of pants					
Puts on pants					
Takes off shirt					

Self Help Checklist *(Continued)*

Skill	Unable	< 25% Independent	25% Independent	50% Independent	100% Independent
Puts on shirt					
Takes off socks					
Puts on socks					
Takes off shoes					
Puts on shoes					
Pulls Zipper Pull					
Latches Zipper					
Buttons					
Brushes teeth					
Brushes hair					
Bathing					
Self feeds with spoon					
Spears with fork					
Washes hands					
Toileting					

Self Help Checklist *(Continued)*

Skill	Unable	< 25% Independent	25% Independent	50% Independent	100% Independent
Indicates need to go to the bathroom					

Fine Motor Skills Checklist

Please indicate the amount of assistance your child needs to complete the following by placing a check in the corresponding box.

Skill	Unable	< 25% Independent	25% Independent	50% Independent	100% Independent
Grasps crayon, pencil or marker					
Snips with scissors					
Cuts out shapes with scissors					
Writes his or her name					
Strings small beads					
Manages containers such as lunch boxes, baggies, and Tupperware					

Behavior

38. Does your child become easily frustrated?

☐ Yes ☐ No

If yes, please explain:

39. Does your child have difficulty following rules?

☐ Yes ☐ No

If yes, please explain:

40. Does your child have an easier time performing activities when following a structured routine?

☐ Yes ☐ No

41. Does your child frequently modify or interchange activities so that they are of interest to him or her?

☐ Yes ☐ No

42. Does your child have episodes of uncontrolled behavior?

☐ Yes ☐ No

If yes, please explain:

43. Does your child need gratification "right now" when asking for something?

☐ Yes ☐ No

44. Is organization a challenge for your child (e.g., having an uncluttered workspace, finding and putting away materials neatly in a backpack)?

☐ Yes ☐ No

If yes, please explain:

Visual-Perceptual Skills

45. Does your child watch others for visual cues when performing the same task? ☐ Yes ☐ No

46. Does your child write at a slow pace compared to his or her peers? ☐ Yes ☐ No

47. Does your child have legible handwriting? ☐ Yes ☐ No

48. Does your child leave appropriate spacing between letters and words when handwriting? ☐ Yes ☐ No

49. Does your child mix uppercase and lowercase letters when writing (e.g., combining letter cases within words)? ☐ Yes ☐ No

50. Does your child use printing after being exposed to cursive writing in the classroom? ☐ Yes ☐ No

51. Does your child experience difficulty with visual-spatial skills (e.g., putting together puzzle, writing words on the writing lines, leave appropriate spacing between words and sentences during handwriting exercises)? ☐ Yes ☐ No

52. Does your child have difficulty with activities that involve visual figure-ground: identifying whether objects are placed in the background or foreground (e.g., finding a certain object in a crowded drawer, seeing "hidden pictures" in books)? ☐ Yes ☐ No

53. Does your child have difficulty tracking a moving object with his or her eyes (e.g., before catching a ball)? ☐ Yes ☐ No

Sensory Processing

54. Does your child display extreme sensitivity to sensory input (e.g., sounds, touch, smell)?

☐ Yes ☐ No

If yes, please explain:

55. Does your child seem to seek or crave certain types of sensory input (e.g., jumping a lot, frequently spinning, often fidgeting with hands)?

☐ Yes ☐ No

If yes, please explain:

56. Does your child require more time than other children to process verbal information (i.e., takes additional time to comprehend and respond to questions)?

☐ Yes ☐ No

If yes, please explain:

57. Is your child flexible with change (e.g., changes in schedules or activities)?

☐ Yes ☐ No

58. How does your child tolerate group situations (e.g., playing with others on a playground, working together with peers in the classroom)?

59. Does your child hyper focus on certain activities?

☐ Yes ☐ No

If yes, please explain:

60. Does your child display any sensitivities to clothing, eating certain foods, or sleeping with particular bedding (e.g., tags in shirts, refusal to eat foods due to texture, only sleep with particular "soft" or "cozy" blankets)?

☐ Yes ☐ No

If yes, please explain:

61. Other sensory concerns?

Social Skills

62. Does your child have difficulty making and keeping friends? ☐ Yes ☐ No

63. Does your child have difficulty taking turns when playing games with peers? ☐ Yes ☐ No

64. Does your child attempt to control social situations? ☐ Yes ☐ No

65. Is your child able to carry conversations with peers and adults (e.g., ask and respond to questions, maintain conversation without interrupting other person)? ☐ Yes ☐ No

Practices & Policies

(As of January 1, 2020)

I. RATES

A. First Steps To An Evaluation

Initial Consultation Meeting (Parent Meeting: Optional): $250/session (45 minutes)

Evaluation (At Little Hands Clinic): $195 (45-60 minutes)

Deposit for this evaluation charge is pre-paid in order to reserve the day/time & non-refundable.

Evaluation (At School): $195 (45-60 minutes)

B. Follow Up To Evaluation

(Reports are required before therapy begins)

Evaluation Report: $195/hour

Average time 1-3 hours. Reports are received after payment is made.

Parent Education Meeting: $195/session (45 minutes)

A parent/therapist meeting is required 6 to 8 weeks after initiating weekly therapy.

C. Weekly Therapy

Treatment Session: $155/session (45 minutes - Occupational Therapy)
$160/session (45 minutes - Speech Therapy)

If a child is over 10 minutes late to be picked up, additional charges will be applied as per hourly rate)

Treatment Sessions in Child's School or Home: $195/session (45 minutes)

Consultative Services: $195/hour

These include progress reports, home programs and/or email/phone calls that exceed 10 minutes.

School Observations: $195/hour

May be additional if over 10 miles of driving.

Nutrition/Dietician Services: $195/hour

D. Additional Reports/Re-assessments

Progress Report (every 4-6 months): $195/hour

Average time: 1-2 hours.

E. Parent Consultation Services $250/session (45 minutes)

Behavior plans, implementation of home strategies, school placement, prioritizing therapies, sibling challenges, and public school services consultation (IEP & 504)

II. PROCESS/DESCRIPTION OF SERVICES

All Little Hands Clients are evaluated and follow the below process before treatment to determine rate/type of treatment.

A. Initial Consultation Meeting

(Recommended but optional)

The therapist and parent(s) discuss concerns related to the child's functioning. The therapist provides recommendations for an evaluation, treatment, and/or home strategies.

Cost: $250

B. Evaluation

(Required for treatment)

Approximately 1 to 2 hours of testing using standardized and/or informal measures to assess the child's strengths/weaknesses and determine the need for weekly therapy.

Cost: $195 **(EVALUATION REPORT NOT INCLUDED)**

C. Evaluation Report

(Required for treatment)

Written description of administered tests, the child's performance, and areas to target in treatment (if applicable). This report includes a treatment plan (when treatment is recommended) with baseline areas of functioning and 4-6 month goals.

Cost: $195 per hour (ranges between 2 to 4 hours)

D. Progress Report

(Required for continued treatment at Little Hands OT)

This report describes the child's progress toward targeted goals, his/her current levels of functioning, and the new treatment plan (if continued treatment is recommended). Progress reports are provided every 4 to 6 months (depending on the frequency of treatment sessions). If additional progress summaries are provided (e.g., via email) they will billed in increments of

Cost: $195 per hour

E. Evaluation Feedback Meeting

(Strongly recommended but optional)

The therapist and parent(s) review the evaluation report and treatment recommendations.

Cost: $195 per hour

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F. Consultative Services

(Depending on needs of client)

The therapist provides recommendations and strategies for home and school settings to optimize the child's functioning and address areas of concern. Classroom observations, consult with parents/school staff, and therapy collaboration with other specialists are also commonly provided.

Cost: $195 per hour

G. Treatment Sessions

(Depending on needs of client)

Individual, paired, and small group sessions are available. Co-treatment sessions (speech/language therapy combined with occupational therapy) are also offered when appropriate. Treatment sessions are typically 45-minutes in duration (with the remaining 15 minutes of the hour being used for treatment note-writing and planning).

Cost: $155/session (45 minutes - Occupational Therapy)
$160/session (45 minutes - Speech Therapy)

III. PARKING & PROCEDURES DURING SESSIONS

On-site parking is available. Parents are not **required** to stay at the clinic while their child is participating in therapy sessions or evaluations. We highly value parent participation in sessions although they are not required, please contact your therapist ahead of time (**at least a week**) to arrange for a session **WITH** your child, due to privacy of other families participating at Little Hands.

IV. CANCELATIONS/NO-SHOW'S

There is no charge for cancelled services **due to your child's illness** when **at least 24 hours** notice is given. Otherwise, missed sessions due to child's illness will result in a charge for the full cost of the session. Please notify the therapists of **planned vacations or other conflicts with at least 2 weeks** advanced notice otherwise sessions will be fully charged. Notice of changes in schedule (**sickness and/or vacation must be in the form of email or phone call to therapist**).

V. PAYMENT & INSURANCE

Invoices for therapy sessions are electronically delivered at the end of each month. **Payment is due upon receipt; late fees are applied if payment is not received by the 15th of the month. The full cost of the evaluation write up report is due once the report is complete and invoice is received, prior to receipt of the written report. Report will be provided once payment of report is received.**

If invoices are received late 2 months in a row, Little Hands has the right to request pre-paid monthly invoices for services (payment for upcoming month of services must be received before the 5th of each month). A credit card will be held on file and used in the event of a 30 day past due invoice.

While we provide no direct insurance billing from this office, we are happy to provide you with super bills, which are receipts for therapy services with relevant diagnosis and treatment codes. Periodically, insurance companies may request documentation regarding Occupational Therapy services, and we routinely provide evaluation and updated progress reports as requested by insurance companies. **Preparation of these documents is billed in increments of the treatment rate.**

VI. TERMINATION OF THERAPY

If you terminate therapy, for any reason, we require **at least 2 weeks of sessions' prior written notice** in order for the therapist to transition the child out of therapy and complete closure. We reserve the right to terminate our relationship with a client at any time for any reason. Unless circumstances require otherwise, if we terminate the relationship, we will provide at least 2 sessions' prior notice.

VII. DELINQUENT ACCOUNTS

Invoices will be sent via email at the end of each month to be received by the 1st of each month. Invoices are due upon receipt. **Late fees are applied if payment is not received by the 15th of the month.** Collection of past due accounts

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will be initiated if non-payment of account extends beyond 60 days. A credit card will be held on file and used in the event of a 30 day past due invoice. You will be responsible for payment of reasonable attorney fees and all collection costs, including court costs in the event action is commenced to collect past due accounts. Collection agency fees shall be no less than 35% of the outstanding balance. **If invoice payments are received late 2 months in a row, Little Hands has the right to request pre-paid monthly invoices for services. Payment for upcoming month of services must be received before the 5th of each month.**

VIII. COVID-19 DISCLOSURE, ACKNOWLEDGMENT AND LIABILITY WAIVER

By signing this form, I acknowledge the contagious and still unknown nature of the COVID-19 virus and voluntarily assume the risk that I or my family members (child) may be exposed to or infected by COVID-19 and that such exposure or infection may result in personal injury, serious illness, permanent disability or death. I understand that the risk of becoming exposed to or infected by COVID-19 may result from the actions, omissions, or negligence of myself and others. I voluntarily agree to assume all of the foregoing risks related to COVID-19 and accept sole responsibility for any injury to myself or my invitees, including, but not limited to, personal injury, illness, disability, death, damage, loss, claim, liability, or expense, of any kind, that I or my child/family member may experience or incur in connection with visiting Little Hands for therapy. I hereby release, discharge, covenant not to sue, and hold harmless to Little Hands, their employees, agents, representatives, associates and insurers (collectively "Released Parties"), of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of Released Parties whether a COVID-19 infection occurs before, during, or after my or my child's visit at Little Hands. I acknowledge and agree to take appropriate precautions, including maintaining good personal hygiene including frequent hand washing or sanitizing and staying at least six feet from persons not in my party or related to me. I further agree to make every effort to follow all rules, policies, and safety precautions established by the Centers for Disease Control and Prevention ("CDC"), the California Department of Public Health ("CDPH"), or other State or Federal agency, whether posted in writing or explained to me verbally, and take all necessary steps to reduce the risk of illness to me and my party. I specifically acknowledge and agree to not come to Little Hands if anyone in my family are experiencing any of the symptoms of COVID-19 as identified by the CDC and/or the CDPH including cough, shortness of breath or difficulty breathing, fever, chills, muscle pain, sore throat, or new loss of taste or smell. By signing below, I understand that I am releasing any potential Claims against Little Hands and in return I will be permitted to visit and participate in activities at and around the clinic.

IX. CHANGE IN POLICIES

The terms and conditions in this policy may change from time to time. Such changes will occur with 30 days written notice.

Authorization

☐ I agree to the above policies/practices for my child.

Child's Name:

Your Full Name:

Date:

Availability: (Please specify days/times that your child is available for weekly therapy.)

Authorization for Credit Card Use

All information will remain confidential

BILLING INFORMATION

Name on Card

Billing Address

Billing City

Billing State

Billing Zip

Credit Card Type

☐ Visa ☐ Mastercard ☐ Discover ☐ AmEx

Credit Card Number

Expiration Date

Identification Number

Authorization

☐ I authorize Little Hands Occupational Therapy, Inc. to charge this credit card for late payments on invoices due and payments associated with any documentation, report writing and or consultation which have not been paid in due time according to the practices and policies.

Date:

Notice of Privacy Practices

Treatment: We may use and disclose your child's health information as part of assessment and intervention procedures. In addition, we may use and disclose your child's information with other caregivers, professionals, or persons working with your child, only when given written consent. If a parent/legal guardian would like consultation with other caregivers/professionals/persons, he or she shall sign and submit a Release of Information form.

Billing: We may use and disclose your health information to obtain payment for services we provide to you.

Your Authorization: You may give us written authorization (Release of Information) to use your child's information or disclose it to anyone for any purpose. If an authorization is provided to us for any individual or entity you may revoke the authorization in writing at any time.

To Your Family and Friends: We must use and disclose your child's information to notify your family or any other person responsible for your child's care of your child's location, and/or general condition. If you are present we will provide you with the opportunity to object to such disclosures. Our Transportation Release form only grants permission for an individual to transport your child. If you would like for us to share information with those who may be transporting your child, we require a Release of Information for that individual. We will only provide information to individuals that have been identified on the Release of Information form.

Marketing: We will not use your child's information for marketing purposes without a written release.

Required by Law: We may be required to provide information to law officials under certain circumstances. We are mandatory reporters. We may be obligated to use or disclose your child's information if we believe that your child is a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes.

National Security: We may be obligated to use or disclose your child's information as required for national security: to military authorities or armed forces personnel, to authorized federal officials as required for lawful intelligence, counter-intelligence, and other national security activities, or to correctional institution or law enforcement official, having lawful custody of health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use your child's information for appointment reminders (i.e. voice mail, reminder cards, post-it notes) In order to ensure adherence to confidentiality policies, email communication will be limited to scheduling. When discussing your child via email, parent/legal guardian is requested not to use his/her child's name in the text (initials or treatment day/time would be acceptable).

Clinic Visits: Occasionally persons (e.g., parents or related service providers) may request to visit the facility or may be participating in a therapy session with their child. These visits will be scheduled only if it is determined not to interfere with a child's therapy session. Should you be attending your own child's therapy session, you are reminded that the identity and other sensitive information of any and all other children and families present in the clinic should be treated with confidentiality, and should not be discussed outside of the clinic.

We reserve the right to change our privacy practices at any time. If we change the privacy practices, we will issue a revised notice of privacy practices.