Creative Hands
Occupational Therapy, Inc.

Welcome to Creative Hands Occupational Therapy! Thank you for choosing us for your childs OT needs. We are excited to begin therapy and be a small piece of your childs journey.

Arrival Information

We offer parents a tour of our clinic at the first Evaluation. After your child transitions well to the Therapist, parents are asked to wait in the lobby or in your vehicle. We have an open area setting with multiple children and therapists sharing common areas.

Will weekly therapy be the same time every week? How long? How often?

Therapy will be 1 or 2 times a week depending on the child's needs and evaluation scores. Therapy will be the same days and times every week, unless your child's therapist contacts you otherwise. The Evaluation and Therapy sessions last 1 hour - please be on time for arrival and pick up to be considerate of the therapist schedule.

When will my child start weekly therapy?

IT TYPICALLY TAKES 1-2 WEEKS AFTER THE EVALUATION TO START WEEKLY OT SESSIONS. After the OT evaluation, we will contact you when we can start weekly OT sessions. The therapist will contact you soon to give you their contact information, and answer any questions you may have about the Evaluation or your childs Plan of Care.

What OT goals are my child working on?

The office will email you a copy of the OT Evaluation and the Plan of Care, which shows the OT goals specific for your child.

Reschedule a weekly appointment?

Contact your child's therapist directly to make any schedule changes.

Cancellation policy?

In the event of illness or unavoidable circumstance, please attempt to reach your therapist directly, we may be able to reschedule. As a courtesy to our therapists and other clients, please contact us at least 24 hours prior to your appointment time to cancel. A no show or a cancellation not made 24 hours before the appointment may incur a fee. Consistency and attendance at all appointments benefits the child in reaching their maximal potential and reaching their established goals.

PAYMENT OR BILLING question?

Please call our billing office at (910)262-5701

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INTAKE PACKET

Childs LEGAL Name	Date of Birth	Male ☐ Female ☐
Parent/Guardian Name	Phone/Cell #	
Address		
Email		
NAME of DOCTOR	Doctor Office	Up to date on Well Child Visits? YES ☐ NO ☐
Parent Concerns		

INSURANCE INFORMATION

Medicaid : Yes No	**Medicaid Number**

Primary Insurance:	
Policy Holder Name on Card	Policy Holder Date of Birth
Plan #/ Member# Tricare only- Social Sec #	Group #

DO YOU HAVE A SECONDARY INSURANCE? YES NO

Secondary Insurance:	
Policy Holder Name on Card:	Policy Holder Date of Birth:
Plan #/Member Social/ID #	Group Number

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CHILDS NAME:_____

PLEASE LIST ANY DIAGNOSIS GIVEN BY A DOCTOR:

_____

PARENT CONCERNS:

_____

_____

MEDICAL HISTORY:

ALL ALLERGIES:_____

CURRENT MEDICATIONS:_____

PREGNANCY/BIRTH: NORMAL EARLY LABOR IF EARLY, HOW EARLY?_____

COMPLICATIONS? IF YES, PLEASE DESCRIBE_____

_____

DID YOUR CHILD CRAWL ON HANDS AND KNEES? NO YES WHAT AGE?_____

WHAT AGE DID YOUR CHILD START TO WALK? _____

HOSPITALIZATIONS AND/OR SURGERIES:_____

LIFE HISTORY:

PERSONS LIVING IN HOME: PARENT 1 PARENT 2 SIBLINGS OTHER ADULT OTHER CHILD

SCHOOL/DAYCARE ATTENDING:_____ GRADE:_____

DOES YOUR CHILD HAVE AN I.E.P.? NO YES-

WHAT I.E.P.SERVICES?_____

PREVIOUS/ CURRENT OTHER THERAPIES? SPEECH PT ABA OTHER:_____

Insurance/Billing/Cancellation policy

As a courtesy, we will verify and file your claim with your insurance carrier; however, we cannot guarantee payment. You are responsible for payment of any deductible, co-payment/co-insurance, and any non-covered services. If your insurance company denies any part of your claim or if you or your physician elects to continue therapy past your allowed/approved visits, payment will be expected from you. Verification is only an explanation of benefits based upon information that we received from your insurance carrier. It is not a guarantee of payment. Please contact your insurance carrier directly to confirm your individual benefits for Occupational Therapy services. CHOT reserves the right to bill a patient directly if their insurance company is unresponsive or particularly slow in making payment. Accounts with balances greater than 60 days without payment will be considered delinquent. Delinquent accounts are subject to further collection action including placement with a collection agency. You are responsible for providing all accurate and current insurance policies and information prior to the Evaluation, and in a timely manner when you receive new insurance. Failure to provide accurate insurance information may result in denials from your insurance carrier and will be considered patient financial responsibility.

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Cancellation Policy: If you need to cancel a scheduled appointment, please let your therapist know as soon as possible, we may be able to reschedule. A cancellation not given 24 hours before the therapy session may be charged a $20.00 fee. A "no show" for a therapy session may incur a $40.00 no show fee. In the event of illness or unavoidable circumstance, please attempt to notify your childs therapist. Consistency and attendance at all appointments benefits the child in reaching their maximal potential and reaching their established goals.

Termination of services can occur following three sessions that were canceled without appropriate notice in a 60-day period.

I have read the above statements. It is my understanding that I am financially responsible to CHOT for the services provided to my dependent. I authorize my insurer to pay any benefits directly to CHOT. I agree to pay the full amount of all charges incurred by the above-named patient that are not covered by my insurance carrier.

Parent/Guardian Signature: _____

Date: _____

Consent to provide Treatment: I hereby authorize CHOT through its appropriate personnel to perform appropriate assessment and treatment procedures to my child relating to his/her diagnosis.

Parent/Guardian Initials: _____ **Date:** _____

Acknowledgement of Risk and Release of Liability

PLEASE READ, SIGN, AND INITIAL AT THE BOTTOM OF THIS SHEET

I understand and acknowledge the risks inherent in some of the therapy activities conducted at the clinic, including, but not limited to, the use of suspended therapy equipment and the physical exertion experienced during exercise and play activities. I further acknowledge that my child's participation in therapy activities at the clinic is voluntary in nature. I affirm that my child is in good health and is physically capable of participation in the activities at the clinic for which he or she is scheduled. I acknowledge that it is the recommendation of Creative Hands that my child be examined and cleared for participation in the scheduled activities by a medical professional prior to engaging in the contemplated activities.

In consideration for allowing my child to participate in therapy, I hereby release Creative Hands Occupational Therapy Services, Inc., its owners, officers, employees and agents from and against any and all actions, claims, demands, charges, damages, costs, losses and liabilities on account of any and all injuries, illness or other damages, including death, which may result either directly or indirectly from my child's participation in therapy at the clinic. I agree not to take any legal action of any kind against Creative Hands Occupational Therapy Services, Inc., its owners, officers, employees or agents for damages sustained as a result of my child's participation in therapy at the clinic. I further agree to indemnify and hold harmless Creative Hands Occupational Therapy Services, Inc., its owners, officers, employees and agents from any and all claims, judgments or costs. This release and indemnification shall be effective as to my and my child's heirs, executors, and administrators and any other persons claiming through or on behalf of myself or my child.

I confirm that I have had sufficient opportunity to read these policies and procedures, including the Release of Liability, that I have actually read it and that I understand its contents and its effect on my child's legal rights.

Date: _____

Name of Child (print): _____

Signature of Parent/ Guardian: _____

Recurring Payment Authorization Form

If you have PRIVATE INSURANCE or are SELF PAY please fill out the payment information below.

Your scheduled weekly payment will be automatically charged to your Credit Card on Tuesday of every week, on the week following the visit. You will be charged the co-pay amount indicated by your insurance company for each visit.

A receipt for payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior notification will be provided for each debit.

I **(full name)** _____ parent/guardian of

Childs Name: _____authorize Creative Hands to charge my credit card for co-pay or private pay for payment of the therapy session.

Please check 1 option below:

___ I have insurance and would like to have recurring payments set up for my co-pay. (Note: You will be billed for any balances not paid by your insurance company.)

OR

___ I am not insured and agree to private-pay using payment of $212 for each Evaluation and $95 for each on-going Therapy visit.

Credit Card Information:

☐ Visa ☐ MasterCard

Cardholder Name:

_____

Account Number:

_____

Exp. Date:

_____

Security Code: _____

Billing Address: _____

City, State, Zip: _____

Phone:_____

Email:_____

SIGNATURE:_____ **DATE:**_____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Creative Hands in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Creative Hands may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

Supply Clinic
58 Physicians Drive Suite 106
Supply, NC 28462
Phone: 910-755-6075
Fax: 910-755-6076

Creative Hands
Occupational Therapy, Inc.

Holly Ridge Clinic
624 U.S. Highway 17 S Suite 5
Holly Ridge, 28445
Phone:910-329-4444
Fax: 910-406-4111

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient's Legal Name:_____

Date of Birth:_____

Creative Hands Occupational Therapy, Inc. has my authorization to release all records, discuss my child's treatment and consent for the mutual exchange of information to/from the following individuals:

Childs Doctor/ Doctors Office:

_____

Childs School/Daycare:

_____

All others - family members, caregivers, social worker, psychologist, transporters, etc:

_____

_____

CDSA patients only- I hereby authorize Creative Hands Occupational Therapy to release records to CDSA _____Initials of Parent/Guardian

I authorize release of my child's records and exchange of information in accordance with the specifications listed above and authorize Creative Hands Occupational Therapy, Inc. to discuss my child's care with the individuals specified above. I understand I may revoke this authorization at any time by signing a separate revocation form.

Parent/Guardian Printed Name:_____

Signature of Parent/Guardian:_____

Date: _____