KidPower Therapies
Occupational Therapy • Evaluation, Treatment & Training
20 Newman Ave Suite 1025, Rumford, RI 02916
kidpowertherapies@gmail.com (401) 610-0639

Please complete all of the information below

Child's name:____

Date of Birth: ______________________ Age:________ Gender:_______________

Home address:

____
Street
____

City State Zip

Parent(s) / guardian : ____

Parent / guardian email address: ____

Parent / guardian phone: (mobile) _______________________ (alternate) ___________________

EMERGENCY CONTACTS

Emergency contact 1 name: ____

Emergency contact 1 phone: (mobile) ____________________ (alternate) ___________________

Emergency contact 2 name: ____

Emergency contact 2 phone: (mobile) ____________________ (alternate) ___________________

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PHYSICIAN INFORMATION

Primary Care Physician:

Name: ____

Phone:_________________________________ Address:____________________________________

Specialist(s)

Name: ____

Phone:_________________________________ Address:____________________________________

Name: ____

Phone:_________________________________ Address:____________________________________

ALLERGIES (FOOD, MEDICATION, ENVIRONMENTAL, OTHER)

TYPE OF ALLERGY	TYPICAL REACTION	TREATMENT

MEDICAL CONDITIONS CURRENTLY BEING TREATED

CONDITION	DATE OF ONSET	TREATMENT	TREATING PHYSICIAN

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MEDICATIONS

MEDICATION	DOSE	FREQUENCY	REASON FOR TAKING	PRESCRIBING PHYSICIAN

DIAGNOSIS (Check All That Apply)

Autism High Functioning Autism Sensory Processing Disorder

Cognitive Deficit Anxiety Disorder Depression

Attention Deficit (Type:____________) Obsessive Compulsive Disorder

Learning Disability (Type:____________) Other:______________________________________

BIRTH HISTORY/ADOPTION : (Please be as specific as possible.)

Type Of Delivery: Vaginal Cesarean

Length Of Pregnancy: _______ Weeks

Pregnancy Complications: Yes No (If Yes, Please Describe)

Prenatal: ____

____

Postnatal:____

____

NICU: Yes No Concerns__________________________ Length of stay________________

Intervention prescribed (related to complications):

____

____

ADOPTION:

Age at time of adoption: ________________________

Domestic International : Country of origin _________________________

SCHOOL HISTORY:

School currently attending : ____ Grade:____________

Teacher/Contact:_______________________________ Telephone: ________________________________

Has this child ever received special services? ______ (If yes, please check below)

Service	Site (Home, School, Other Agency)	Years (Ex.1999-2001)
Occupational Therapy		
Speech-Language Therapy		
Physical Therapy		
Psychological Services		
Social Work Services		
Special Education (Type)		
Listening Therapy		
Auditory Integration Training		
Aba~ Behavioral Support		
Relationship Development Intervention		
Neurofeedback		
Neuropsychological		

If currently receiving OT services, where and when was the last OT evaluation?

____

PLEASE INCLUDE COPIES OF MOST RECENT EVALUATIONS WITH THIS PACKET, THANK YOU.

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DEVELOPMENTAL HISTORY:

When were you first concerned about your child's development/abilities?

____

____

As an **infant**, was your child: (check any that apply)

Fussy? Over sleepy/difficult to rouse?

Did this child respond to cuddling? Feeding difficulties?

Please indicate **age** (if known) when your child began:

to sit unsupported ________ to use a spoon ________ to crawl________

to toilet train: urine________ bowel________ to walk alone ________

to dress independently________ to say first word (mama, dada) ________

to tie shoe laces ________ talk in two to four word sentences ________

to separate easily from mother/father ________

Compared to other children, did/does your child have difficulty learning to: (check any that apply)

Talk? Understand? Gross motor skills (walking, hopping, riding bicycle, etc)?

Fine motor skills (fastening buttons, zippers, tying shoelaces, drawing, etc.)?

Early school-related skills (reaming colors, saying alphabet, recognizing coins, etc)?

Sit still for TV or stories? Play/socialize with other children?

Describe this child's personality and temperament in general?

____

____

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Does your child fall asleep and stay asleep through the night? ________ if no, please describe:

____

Does your child eat all foods? ________ if not, describe (textures, temperatures, tastes, accept new foods): ____

Does your child play with younger/older and age peers appropriately? ________ if no, please describe:

____

Is your child able to use a pencil/marker/scissors/beads/blocks appropriately? ________

Does your child complete life skills independently according to age? ________

Any stresses/events that have occurred? (changes in school, loss of family member, hospitalization)

____

____

How do you best describe your child's strengths?

____

____

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What are your concerns regarding your child's development? (speaking, understanding, using hands, arms, legs, coordination, learning new motor skills, eating or social/emotional behaviors)

____

____

What do you hope to accomplish by seeking evaluation and/or intervention services? (feel free to add an additional page to further explain)

____

____

Are there any physical restrictions/needs? ________ if yes, describe:

____

____

Other necessary information:

____

____

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IMPORTANT: Must be completed before evaluation / treatment

The information contained here is accurate as of today.

I hereby give permission to evaluate and provide intervention services to my child

beginning on this day: ______/_______/_______

____

Signature

I agree to all policies and procedures related to billing as outlined in the registration packet.

____

Signature

Form completed by: ___________________________________ ________________________________

Name Relationship to child

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Authorization for Release of Information

Complete for All Authorizations

I hereby authorize the use or disclosure of my personal health information (PHI) as described below. I understand that this authorization is voluntary. I understand that, if the organizations authorized to receive my PHI is not a health plan or health care provider, the release information may no longer by protected by federal privacy regulations.

Patient name:_______________________________________ DOB:_______________________

Persons/organizations authorized to release your PHI	Persons/organizations authorized to receive your PHI
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Specific description of PHI to be released (including date(s)):

____

____

Specific restrictions you want placed on release of your PHI:

____

____

I understand that this authorization will expire one year from the date of signature. The expiration date will be _____/_____/_____. I understand that I may revoke this authorization at any time by notifying the releasing organization in writing, but my revocation will not affect any releases made of other actions taken before the date of my revocation.

Complete for all authorizations

Signature of patient or patient's representative___________________________________ Date___________

Printed name of patient/patient's representative____

Relationship to the Patient____

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Rate Schedule
9/10/2020

Procedure	Payment Rate
Individual Treatment	$125 per session
OT Evaluation	$750
Sensory Integration Praxis Test (SIPT)	$1000
Consultation	$350

Payment is expected at the time of visit; for all school visits, please remit weekly payment to the address above. All payment for services is expected within 30 days of service unless previous arrangements are made. Invoicing is available.
Cash, checks, or VENMO are appreciated.

Please note that I do not participate in any insurance plan as a provider, therefore most plans consider me to be an *out of network provider*.

If you are interested in accessing your medical insurance plan, call your insurance company to find out what services your plan covers.

Additional questions to ask insurance representatives:

- Does my plan provide coverage for occupational therapy?
- Are evaluations covered?
- How many therapy sessions are allowed under my insurance plan?
- What out-of-network coverage do I have if I go to a provider that does not accept my insurance?
- Do I need to obtain prior authorization or a referral for therapy services?

If you are submitting your occupational therapy claims to insurance for reimbursement, I will gladly send you a receipt with coding for insurance ready submission. Please let me know in advance so that I can prepare your child's documentation in insurance ready format. I will assist you with any other insurance questions to the best of my ability.

Cancellation policy: Call or email change in appointment at least 24 hours in advance. This allows children waiting for appointments to expedite access to services. Thank you

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