OCCUPATIONAL THERAPY INTAKE FORM - CHILD

Our Mission Statement: To provide the client an opportunity to achieve their full potential while receiving individualized therapy services in a positive, caring environment.

Today's Date: _____

Client Name: _____ DOB: _____

SS#: _____-_____-_____ School Currently Attending _____

Address:	
City, State & Zip:	
Phone:	

Emergency Contact:	
Phone:	

Who Referred You? _____

Parent/Guardian 1:

Please Mark One: ☐ Bio Parent ☐ Step Parent ☐ Foster Parent ☐ Legal Guardian

Name: _____

DOB: _____ SS#: _____

Phone: _____ Cell: _____

Parent/Guardian 2:

Please Mark One: ☐ Bio Parent ☐ Step Parent ☐ Foster Parent ☐ Legal Guardian

Name: _____

DOB: _____ SS#: _____

Phone: _____ Cell: _____

Emerge Therapy Services

IF THE CLIENT IS A MINOR PLEASE COMPLETE THIS SECTION:

Are you (Mark One): ☐Parent (Bio/Step) ☐Foster Parent ☐Legal Guardian

Who has legal custody of this child? _____

If divorced, foster parent, or have legal guardianship, please provide documentation that verifies you have permission to make medical decisions for the minor.

Is the parent/guardian or any other family member in the home currently receiving counseling services elsewhere? ☐ Yes or ☐ No

INSURANCE INFORMATION (Please provide us with a copy of your insurance card)

Primary Insurance:

Name of Policy Holder: _____

Insurance Company: _____

Policy Number: _____ Group # _____

Effective Date: _____

Secondary Insurance:

Name of Policy Holder: _____

Insurance Company: _____

Policy Number: _____ Group # _____

Effective Date: _____

INFORMED CONSENT

COMPLETE INFORMED CONSENT, POLICIES AND GENERAL INFORMATION FOR THE PRACTICE OF MENTAL HEALTH CLINICIANS

GENERAL INFORMATION: We are pleased you have chosen Emerge Therapy Services...for your counseling needs. Our clinicians are licensed professionals governed by their respective state boards. Our therapists offer core behavioral health services for the treatment of behavioral disorders and have the capacity to provide effective, equitable, understandable, and respectful quality care and services responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs. **We provide Tier I, Outpatient Behavioral Health individual, family, Dyadic, Psycho-Ed, and group counseling level services.** [IX. C1, C3] Eligibility for services depends on the needs of the beneficiary. Tier 1 and crisis services can be provided to any beneficiary as long as the services are medically necessary. The therapists provide time-limited behavioral health services in an outpatient-based setting for the purpose of assessing and treating mental health.The performing provider must provide services only within the scope of their individual licensure. [IX. C4]
TIER 1: Time-limited behavioral health services provided by qualified licensed practitioners in an outpatient based setting for the purpose of assessing and treating mental health and/or substance abuse conditions. Each beneficiary that receives only Tier 1 Outpatient Behavioral Health Services can receive a limited amount of Tier 1 services. Once those limits are reached, a Primary Care Physician (PCP) referral will be necessary to continue treatment. Eligibility for Tier 2 and Tier 3 services will be determined by an Independent Assessment. We are not authorized to give medical advice or to administer prescriptions.

PCP Collaboration Agreement (Medication Management)
In the event it is recommended that you/your child need medication management, Emerge will consult with your families Primary Care Physician who has the appropriate Prescriptive Authority to ensure quality and compliance.

Our office phone has a confidential voicemail at 479-250-4255. ***In the event of an emergency, if we are not available, please contact or go to your nearest Emergency Room or call 9-1-1.*** It is important to know that as your therapist we cannot guarantee a certain outcome in therapy and in the event that the clinician is not equipped to meet your need, a referral will be provided. **It is against the ACA ethical code for a therapist to see a client concurrently with another therapist, so please be advised.**

OUR RELATIONSHIP: We are by law and ethics required not to have a dual relationship with any of our clients. Therefore, our contact will be limited to the paid sessions you have with me in my office. If we happen to encounter each other socially, it is your option to acknowledge or not acknowledge me. This is an ethical requirement, which protects your confidentiality.

PAYMENT: Being on time will ensure your full session. **Your full payment or co-pay is due upon arrival for your session; Visa/MasterCard credit cards are the only form of payment**

accepted. Clients who carry insurance should remember that professional services are rendered and charged to the clients, not to the insurance company.

HEALTH INSURANCE: If we agree that Emerge Therapy Services will file your claims, Emerge Therapy Services will need a copy of your insurance card, you will be liable to pay your co-pay and Emerge Therapy Services will bill your insurance company for their portion. **While every attempt to utilize your well-earned insurance benefits, you are ultimately responsible for your bill, not your insurance company.** Emerge Therapy Services has no control or knowledge over what insurance companies do with the information submitted or who has access to that information. You must be aware that submitting a mental health claim for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. Third party OBH service payments may be denied based on their rules or policies. [IX. C5] Medicaid Recipients: Outpatient Behavioral Health Services are covered by Medicaid when provided to eligible Medicaid beneficiaries by enrolled providers, have documented proof of medical necessity, Seriously Mentally Ill (SMI) or Seriously Emotionally Disturbed (SED) recipient must be seen directly by a physician within one year after the date of the examination and at least every year thereafter.

COURT TESTIMONY AND SUBPOENA POLICY: Please be aware that all court appearances will be as an expert witness. As such, there is a charge ($250.00) at the time the subpoena is received for preparation, research, travel to and from the courtroom, and court testimony. Consultation with attorneys by phone or face to face will be charged separately and must be paid upfront. You have hired me as a **MENTAL HEALTH PSYCHOTHERAPIST/THERAPIST**. Your clinician is an expert in relationships and gladly testify regarding my observations, if it is in the best interest of the client. However, **we do not provide recommendations for custody or placement of children**. If this is what you are anticipating, please hire a child custodial expert.

Please understand that court fees are not covered by third party payers and are the full responsibility of the client. A nonrefundable fee of $250.00 will be charged at the time the subpoena is received. A fee of $3,000.00 for a full day (over 4 hours), and $1,500.00 for a half-day will apply to all court appearances. Travel, meals, and lodging will be additional expenses when we are called out of town. Any telephone consultations, face-to-face meetings with your attorney or letter writing on your behalf will be charged at a rate of $125.00 per hour.

CONFIDENTIALITY AND PRIVILEGED COMMUNICATION: As licensed professionals, we are bound by Arkansas law (Act 593 of 1979 and Act 244 of 1997) to maintain your privileged communication as that of an Attorney-Client. We will keep confidential who clients are and anything a client shares with the therapist with the following exceptions: 1) the client [legal custodial parent or guardian] directs me to give information to another, verbally and/or in writing,

andreleases me to disclose specific information for a specific purpose. 2) There is a threat of life by homicide, suicide or a clear and imminent danger to human life. 3) I have a strong suspicion of abuse to children, the elderly or the handicapped; I am by law (Act #1208) a mandated reporter. 4) If court-ordered. I/we do consult with other professionals regarding cases in order to better serve the client. Your signature on this document gives us permission to do this.

We maintain counseling information that is beneficial to your treatment. This information typically includes symptoms, medications, progress, test results, diagnoses and a summary of our session, this will continue during the course of your treatment with Emerge Therapy Services.

In accordance with ethical code, Emerge Therapy Services will keep your records for a period of seven (7) years, In maintaining the chart, the clinician, the owner of the chart; but you are the owner of the information, You must sign a release of information for Emerge Therapy Services to share your information with anyone other than yourself. If this is a child, the custodial parent HAS and the non-custodial MAY HAVE a right to review the records. These are considered medical records. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it. In the event of the clinician's death your records will be in a guardianship status with another appointed Mental Health Professional. Disclosure may be required to a legal proceeding. If you place your mental status as an issue in litigation initiated by you, the defendant may have the right to obtain the records and/or testimony by your therapist. Emerge Therapy Services will not release records to any outside party unless we have been authorized to do so by all adult family members who were part of the treatment. If you request a copy of the records, please be aware that there is a charge per page for copied medical records. Emerge Therapy Services must advise you that records read by anyone other than the author are easily misinterpreted. A written summary is more appropriate and less likely to be misread. A copy of the provider service rules will be provided to you for your records. [IX.C8]

ELECTRONIC COMMUNICATION AND SOCIAL MEDIA: Electronic communications such as FAX, e-mail, and cell phone are not protected; therefore, your therapist will limit these communications regarding clients. Your therapist is also bound by confidentiality restraints and relationship constraints that forbid our connecting with clients through social networks. You can become a member of the Emerge Therapy Services professional Facebook page.

Audio & Video Recordings

Emerge Therapy Services strictly prohibits audio or video recordings of any therapy session without all parties' expressed written consent.

BENEFITS AND POTENTIAL RISKS TO THERAPY/LENGTH OF TREATMENT:
Psychotherapy carries with it potential benefits and benefits and risks, be advised that therapy may produce emotional discomfort, as well as positive change. **You may end the therapy relationship at any point, but we ask you to do so in person in session because this will have the greatest benefit to your mental health.** You and the therapist will work together to decide the length of treatment. We will work with you as long as we believe it is beneficial to you.

CANCELLATION: Because we hold the scheduled appointment time for you only, we must have 24 hours notice for cancellation. Unless specifically prohibited by a third party payer (insurance company, federally funded government program, etc.) all clients will be charged a $50.00 fee per therapy hour they fail to show up for without prior notification. This fee is the responsibility of the client and insurance will not cover it. Unless it is a true emergency, you will be charged $50.00 (Intake/therapy appointment). The client holds the right to discontinue services at any time. [IX.C7]

NOTICE OF PRIVACY POLICIES: As required by Federal Regulations: THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Policy: This information is provided to you in response to federal regulations that took effect April 14, 2003. These regulations were issued by the Department of Health and Human Services of the US Government in response to a law called “HIPAA” which was passed in 1996. Emerge Therapy Services cares about your privacy and will always do whatever is necessary to protect it. These regulations are about the privacy of your health and personal information known in the regulations as “Protected Health Information” or PHI. In the process of providing you with proper counseling/therapy, Emerge Therapy Services will collect, use and share certain information you have provided. This policy explains how Emerge Therapy Services collects and would use it if complying with federal regulations. It also describes your rights as they relate to PHI and states how Emerge Therapy Services will protect the security and confidentiality of your information.

SHARING INFORMATION: Emerge Therapy Services can disclose PHI per federal regulations without an authorization from you under these circumstances.

- For treatment purposes, such as to your physician, or hospital, or another therapist who may be involved in your treatment.
- For payment purposes, such as to your insurance company or other third-party payer. For healthcare operations, such as to set up or confirm appointments, or share your PHI with our secretary who is directly involved in the business aspect of billing and payment.

- To communicate with family members or friends who you designate as being allowed to receive this information. For public health reporting purposes.
- For worker's compensation purposes.
- To business associates, such as answering services, collection agencies, etc. These organizations are required to sign agreements with Emerge Therapy Services…to safeguard and protect your PHI.
- As otherwise provided by law.

In all other cases, we will disclose your PHI only upon receipt of a proper authorization signed by you or your legal representative. Because state law that is more stringent, privilege-keeping law binds me, Emerge Therapy Services will continue to ask you to sign consent for all disclosures.

YOUR RIGHT REGARDING YOUR PHI: Although your PHI is the therapist's legal property, you have certain rights regarding your PHI. You have the right to:

- Obtain a paper copy of this notice of information, policy and procedures and informed consent. I will give you a copy at the end of our first session if you would like one.
- Inspect and request a copy of your counseling record. There will be a charge per page for copying your record.
- Request to amend your counseling record.
- Obtain an accounting of disclosures of your counseling information from 01/01/2018 forward.
- Request a restriction on certain uses and disclosures of your information.
- Authorize individuals, including family and friends, access to your counseling information as it pertains to treatment, payments and/or healthcare operations. Revoke your authorization to use or disclose counseling information except to the extent that it has already been disclosed.

MY RESPONSIBILITIES: Emerge Therapy Services has the following responsibilities regarding your PHI:

- Maintain the privacy of your counseling information.
- Provide you with this notice of my legal duties, privacy practices with respect to information I collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if I am unable to agree to a requested restriction.

I reserve the right to change my practices and to make new provisions effective for all PHI I maintain. Should my privacy policies change, I will provide you with an updated copy of such information. I will discontinue to use or disclose your counseling information after I have received a written revocation of the authorization according to the procedures included in the authorization.

For more information or to report a problem: If you have a question, you may contact me. If you believe your rights have been violated, you can file a complaint with the Office of Civil Rights, US Department of Health and Human Services. There will be no retaliation for filing a complaint:

Office of Civil Rights
US Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

If you suspect client or provider fraud in Medicaid, SNAP, TEA please call 1-(800)-422-6641 or email ContactDHSFraud@arkansas.gov.

If you would like to file a complaint against me or my counseling practice [IX. C9]:

Emerge Therapy Services
2713 SE I Street Ste #5
Bentonville, AR 72712

I acknowledge that I have read the statement of disclosure, the complete informed consent, policies and procedures, general information and Notice of Privacy Policies per Federal Regulations. I understand it and I will take responsibility to speak with my clinician if I do not.

INFORMED CONSENT OFFERED / RECEIVED

The Informed Consent documentation contains the below information sections.

- General Information
- PCP Collaboration Agreement (Medication Management)
- Our Relationship
- Payment
- Health Insurance
- Court Testimony and Subpoena Policy
- Confidentiality and Privileged Communication
- Electronic Communication and Social Media
- Audio & Video Recordings
- Benefits and Potential Risks To Therapy/Length Of Treatment
- Cancellation
- Notice Of Privacy Policies
    - Policy
    - Sharing Information
    - Your Right Regarding Your PHI
    - My Responsibilities
- For more information or to report a problem contact information

I acknowledge that I have read the statement of disclosure, the complete informed consent, policies and procedures, general information and Notice of Privacy Policies per Federal Regulations. I understand it and I will take responsibility to speak with my clinician if I do not.

By signing below I am verifying that I have read the Informed Consent documentation and

Please check one

☐ I have been offered a copy and did not keep the copy

☐ I have been offered a copy and have taken a copy with me

Client Name	Date of birth

Legal Guardian Signature	Relationship	Date

CONSENT TO TREATMENT

In order to assist you in the best way possible, Emerge Therapy Services gathers information about you and maintains records of our work with you. All information you provide and records we maintain will be considered confidential, and you have the right to give consent before information can be shared with others. However, there are some limitations to confidentiality and situations in which we might be required to disclose information without your consent.

We are required by law to report suspected child or elder abuse or neglect. We also must take steps to insure safety of clients that are an imminent danger of harm to themselves or others. In cases of emergence, we may disclose information for the purpose of securing emergency medical treatment and/or preventing injury, death, or substantial property destruction. Only information specifically needed to address the emergency will be disclosed. In some cases, the courts may subpoena your records and we would be required to provide the record. Records are also available to staff members; agency legal counsel; reviewers for licensing/accreditation/certification/ and/or human rights purposes; and insurance companies and other third party payors. We may also disclose information to the extent required or permitted by any other state or federal statute or regulation.

You have the right to see your own record and to insert information and/or a statement in your record. You also have the right to discuss any concerns you have about the services of this group with your therapist, the therapist's supervisor, and/or the CEO in accordance with the groups Grievance Policy.

By signing below, I hereby voluntarily and knowingly consent to allow Emerge Therapy Services and any of its therapists, employees and/or agents, to use and/or disclose my health information as deemed appropriate to carry out treatment, payment and/or other health care operations of the organization.

I hereby do consent to appointment reminders. Unless otherwise specified, messages may be left on my voicemail and/or with anyone answering the phone at my contact location.

I consent to my own participation, or as the case may be, authorize the participation of (Clients Name) _____, of whom I have legal custody, in evaluation, assessment, referral and treatment. I acknowledge that no explicit or implied guarantees have been made to me or my family as to the result of evaluation of treatment. I understand that treatment cannot be provided unless I sign this form. I also understand that I have the right to participate in the development of a Treatment Plan and that I may discontinue treatment at any time but agree not to hold the staff liable for any adverse consequences arising out of dropping out of treatment. In case of a medical emergency, I authorize the staff to arrange appropriate

emergency medical treatment for myself or any individual for whom I have authorized treatment. I agree to allow a follow-up questionnaire to be sent to me at termination.

PCP Collaboration Agreement (Medication Management)
In the event it is recommended that you/your child need medication management, Emerge will consult with your families Primary Care Physician who has the appropriate Prescriptive Authority to ensure quality and compliance.

Client Name	Date of Birth

Parent/Legal Guardian Signature	Relationship	Date

PARENTAL CONSENT

CONSENT FOR TREATMENT

Name of Client _____ Age _____ DOB _____

Address _____

Contact information for parents/Guardians:

Parent/Guardian 1: _____ Phone: _____

Parent/Guardian 2: _____ Phone: _____

Who is the minor client and what is his/her relationship to you? _____

_____

PROFESSIONAL DISCLOSURE: Emerge Therapy Services clinicians are licensed by their respective governing boards for their professional licensure. Emerge Therapy Services mental health professionals are not authorized to give medical advice or to administer prescriptions.

CONFIDENTIALITY: Federal regulations effective 4/4/03 (HIPAA) have changed the way we care for your Protected Health Information (PHI). We shall provide you with the complete consent information regarding HIPAA and general practices and policies of this center. By state law, we are also required to keep your information confidential. These are the following exceptions: 1) you direct me to give information to someone and/of give me written consent to do that; 2) I determine that there is a threat of life by homicide or suicide; 3) I have a strong suspicion of abuse to children, the handicapped or elderly; and 4) I am ordered by a judge to disclose information.

FIRST SESSION: 1) Introduction. 2) Determine if we are a good fit. 3) Begin the evaluation and assessment phase. 4) Establish a fee structure. 5) Inform you of the nature of my practice and therapy. 6) Begin to set goals.

PAYMENT CONTRACT: Our standard fee for an individual 45-50 minute counseling session is $125.00. The first session is a Diagnostic Interview and is $250.00. Fees for 45-50 minute marriage and family therapy sessions are $125.00. Additional fees shall be assessed for testing, reports, correspondence, court appearances or consultations with attorneys. Payment

is expected at the end of each session. Only credit/debit Visa or MasterCard are accepted. Any concerns or issues about your payment will be discussed in this first session.

CANCELLATION: Please give 24 hours notice for cancellation of appointments. Failure to do so will result in a $50.00 no show fee.

I have read, understand and agree to consent to treatment of professional counseling at Emerge Therapy Services. I give consent for my mental health clinician to leave a brief voice mail or message on my phone. I further give consent to Emerge Therapy Services to file my insurance claims (if applicable) following federal regulations regarding my payment and healthcare operations.

PCP Collaboration Agreement (Medication Management)
In the event it is recommended that you/your child need medication management, Emerge will consult with your families Primary Care Physician who has the appropriate Prescriptive Authority to ensure quality and compliance.

_____ _____

Signature: Parent or Legal Guardian Date

ROI - WAIVER

RELEASE OF INFORMATION & CONSENT FOR TREATMENT

All information provided herein is true and correct.

I am aware of my child's/my diagnosis and wish him/her/myself to receive treatment at Emerge Therapy Services. I permit its employees and all other persons caring for my child/myself to treat him/her/me in ways they judge are beneficial to him/her. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Emerge Therapy Services to release information, verbal and written contained in my child's/my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries and all other related persons to my child's/my treatment or payment for services provided.

I authorize Emerge Therapy Services to obtain medical records and/or professional information from my child's/my physician or other medical professional as it relates to my child's/my treatment.

The signature below certifies that I have read and understand the above information.

_____ _____

Parent/Guardian Signature Date

WAIVER FORM

I, _____ the parent or guardian of _____ (thereafter referred to as "my child") give permission for my child/me to participate in Emerge Therapy Services programs and services.

I hereby release Emerge Therapy Services principal owners, therapists, employees and representatives and all other individuals or organizations acting on behalf of Emerge Therapy Services, from any and all claims which I or my child may have, resulting from or in connection with my child's/my participation in Emerge Therapy Services programs. This includes, but without limitation, any claim, demands or causes of action for injuries to my child/myself,

including but not limited to injuries resulting from the use of any play/therapy equipment during the program at an Emerge Therapy Services center or at client's homes.

I understand that I should be present at all times during delivery of service to my child/myself. If I choose not to, I understand that the aforementioned statements still apply in my presence or absence during the services provided. This agreement is signed for the purpose of fully and completely releasing, discharging and indemnifying Emerge Therapy Services in connection with their programs from all liability as herein described.

Parent/Guardian Signature

Date

PERMISSION TO SHARE

PERMISSION TO SHARE INFORMATION WITH FAMILY AND FRIENDS

If you wish to grant permission for a friend or family member to accompany your child to appointments on your behalf or for us to share medical/billing information, please specify below. You may revoke this permission at any time by submitting a written statement.

I give permission to Emerge Therapy Services to share the health/billing information of (patient name) _____, DOB ____/____/_____ with the following person or persons:

NAME	RELATIONSHIP	PHONE #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/Guardian Signature: _____

Parent/Guardian (Print): _____

Date: _____

OFFICE POLICIES

LEGAL GUARDIANS MUST ACCOMPANY CHILD TO ALL APPOINTMENTS.
IF YOU ARE NOT THE BIOLOGICAL PARENT THEN YOU MUST BRING PROOF OF CUSTODY.

Please bring registration with you to the patients' first appointment. Do not send it to the office. We welcome you to the office and appreciate the opportunity to provide you with our services. To better serve you, we have established certain guidelines that should increase efficiency. Please review this information and feel free to ask any questions at your appointment.

OFFICE HOURS: Our office staff is available to receive your calls Monday - Friday, 8:00 am to 5:00 pm. The number listed is to reach our staff 479-250-4355.

AFTER HOURS CALLS: In case of an emergency after hours, please call your PCP or local emergency room.

APPOINTMENTS: If you need to change or cancel your appointment, please give at least 24 hours prior notice. **NOTE:** Failure to give this notice will result in your being financially responsible for the appointment. If a first appointment is missed with no explanation this office reserves the right to refuse to reschedule. If two appointments are either canceled without 24 hours notice or without any notice, we will be unable to schedule further appointments but will assist in finding alternative coverage.

INSURANCE: Please let our office know **immediately** if you have any changes in your insurance company, policy, billing, subscriber, etc. If you have a **secondary insurance** the office must know this information before the first appointment. Please bring copies of your insurance card(s) or have the receptionist make copies.

ADULT SUPERVISION: Due to financial constraints and issues of liability, we are unable to provide supervision for patients or their siblings during office visits. Every family is required to make arrangements to provide appropriate adult supervision during appointment times.

_____

Print Patient's Name

_____ _____

Parent/Legal Guardian Signature Date

PAYMENT POLICY

It is the policy of Emerge Therapy Services to collect payment at the time of service. If we will be filing insurance and the deductible has been met, we ask that you simply pay the co-payment required at the time of service.

Parent/Legal Guardian _____ Date _____

PATIENT RIGHTS

PATIENT / FAMILY RIGHTS

Client Name: _____ DOB: _____

1. You have the right to be treated with dignity and respect, as an individual who has personal needs, feelings, and preferences.
2. You have the right to privacy in your treatment, in your care and in the fulfillment of your personal needs, and of protected health information.
3. You have the right to be informed of services available to you in Emerge Therapy Services and of any charges for those services.
4. You have the right to be informed of your rights as a client and of all rules and regulations governing your conduct as a client in these facilities.
5. You have the right to know about your physical condition unless your provider, for medical reasons, chooses not to inform you and so indicates in your records. You have the right to participate in the development of your treatment plan.
6. You have the right to receive information necessary to give informed consent prior to the start of any procedure and/or treatment.
7. You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of your choices.
8. You have the right to voice opinions, recommendations, complaints, and grievances in relation to and your rights, without fear of restraint, interference, coercion, discrimination, or reprisal.
9. You have the right to be free from physical, chemical and mental abuse.
10. You have the right to confidential treatment of your person and medical records. Information from these sources will not be released without your prior consent, except in an emergency, or as required by law, or under third party payment contract. Emerge Therapy Services utilized electronic medical records (EMR) in compliance with HIPPA regulations.
11. You have the right to be assessed for pain and have evaluation and management of pain if indicated.
12. You have the right to file a complaint if you feel you have been discriminated against because of race, color, sex, religion, national origin, or disability.
13. You have the right to request the opinion of a consultant at your expense or to request an in-home review of the individual treatment plan, as provided in specific procedures of the facility.

The safety of health care delivery is enhanced by the involvement of the patient and/or family, as appropriate to his/her condition, as a partner in the healthcare process. Emerge Therapy

Services has identified the following patient and family responsibilities and educates the patient and/or family about these responsibilities during the admission process and as needed thereafter.

Responsibilities include at least the following:

1. **Providing Information**

    - The patient and/or family are responsible for providing, to the best of their knowledge, accurate and complete information about present complaints, past illness, hospitalizations, medications, and other matters relating to the patient's health
    - The patient and family are responsible for reporting perceived risks in their care and unexpected changes in the patient's condition.

2. **Asking questions:**

    - Patients and/or family are responsible for asking questions when they do not understand what they have been told about their care or what they are expected to do.

3. **Following instructions:**

    - The patient and family are responsible for following the care, service, of treatment plan developed. Further, patients and family are responsible for following the program rules and guidelines. They should express any concerns they have about their ability to follow and comply with the proposed care plan of course treatment. Every effort is made to adapt the plan to the patient's specific needs and limitations.

4. **Accepting Consequences:**

    - The patient and family are responsible for the outcomes if they do not follow the care or treatment plan.

5. **Following Rules and Regulations:**

    - The patient and family are responsible for following the rules are regulations concerning patient care and conduct. This includes helping control noise, and disturbances, following smoking policies and respecting others.

6. **Showing Respect and Consideration:**

    - Patients and families are responsible for being considerate of Emerge Therapy Services personnel and property and other patients, their family members, and their personal property.

7. **Meeting Financial Commitments:**

    - The patient and family are responsible for promptly meeting any financial obligation agreed to with Emerge Therapy Services.

8. **Legal Issues:**

    - Subpoenas are to be served in person, preferable at least a week in advance, but no later than 72 hours in advance. Any court appearances or legal documentation are subject to fees.

Patient/Legal Guardian Signature	Relationship	Date

Emerge Therapy Services

CANCELLATION POLICY

Dear Parent/Adult Client:

Each time a patient misses an appointment without providing proper notice another patient is prevented from receiving care.

We at Emerge Therapy Services understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least 24 hours notice) at (479) 250-4355. There is a waiting list to see the therapists at Emerge Therapy Services, and whenever possible, we like to fill the canceled spaces to shorten the waiting periods for our patients.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality treatment, it is very important for each patient to attend their visit on time, as well as, being picked up on time

Emerge Therapy Services will impose a $50.00 fee to patients who:

- ❑ Do not show for their appointments;
- ❑ Are more than 15 minutes late for their appointments; or
- ❑ Attempt to cancel their appointments with less than 24 hours notice.

This fee will be billed directly to the patient, as it is not covered by insurance; it must be paid prior to your next appointment. Multiple “no shows” in any 12 month period may result in termination of services from our clinic.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Patient Name (Printed)	Date of Birth

Parent/Guardian Name (Printed)	Parent/Guardian Signature	Date

Child Photography And Video Release Form

Full Name of Child (Print): _____

Parent/Legal Guardian Name (Print): _____

Please initial the correct statement below regarding Emerge Therapy Services photographing and/or videoing your child at our clinic.

_____ I , the parent or legal guardian of of the client above, **grant** Emerge Therapy Services my permission to use the photograph(s) and/or video(s) taken, by Emerge Therapy Services staff, for any legal use, including, but not limited to: publicity, company pamphlets and web content, such as the company website and social media pages. I understand that this permission may be revoked by me in writing at any time.

_____ I , the parent or legal guardian of the client above, **do not grant** Emerge Therapy Services my permission to photograph(s) and/or video(s) the above client.

_____

Parent/Legal Guardian's Name (Print):

_____

Parent/Legal Guardian's Name (Signature):

_____ _____

Date Signed: Telephone Number:

OCCUPATIONAL THERAPY (OT) QUESTIONNAIRE

THERAPY INTAKE QUESTIONNAIRE

Name: _____ DOB: _____

Please complete this questionnaire to the best of your knowledge. The more information you can provide the better that we can serve your child.

Why are you coming in for a therapy evaluation? _____

_____

_____

What are your concerns: _____

_____

_____

What are you hoping to get out of the evaluation? _____

_____

_____

Who is your child's Pediatrician: _____

Does your child have a confirmed diagnosis? ☐ Yes or ☐ No

If yes, what is it? _____

_____

Does your child have any health concerns that we need to know about? _____

_____

_____

Has your child had an evaluation by a PT/OT/ST/DT before? ☐ Yes or ☐ No
If yes, please bring notes/evaluations to the appointment.

FAMILY HISTORY

Who lives in the child's home? (Please provide names / family roles and ages.)

_____

_____

_____

Does the child live in more than one home? ☐ Yes or ☐ No

If yes, please list who lives in that home? _____

_____

EDUCATION INFORMATION

School/Educational program or daycare currently attending _____

_____

Grade Level _____

IEP or Early Intervention Services, Early/Head Start received? ☐ Yes or ☐ No

If yes, what are the services for? _____

_____

_____

_____

_____

Does your child's teacher or daycare provider have concerns about your child's development in any of the following areas?

☐ Gross motor skills ☐ Fine motor skills ☐ Social skills ☐ Self-help abilities

BIRTH HISTORY

Child was born: ☐ Full-term or ☐ Premature
☐ Vaginal or ☐ C-section

Birth Weight: _____ Birth Height: _____

Complications: _____

_____

_____

Did your child stay in the NICU? ☐ Yes or ☐ No If yes, how Long? _____

MEDICAL HISTORY

Does the child have any major medical history? ☐ Yes or ☐ No

If yes, please explain _____

_____

_____

_____

Does the child take any medications? (Please list) _____

_____

_____

_____

Does the child have any allergies? ☐ Yes or ☐ No

☐ Seasonal Allergies ☐ Food Allergies ☐ Drug Allergies
☐ Other Allergies (Please explain) _____

When was your child's last hearing evaluation? Date _____

When was your child's last vision screening? Date _____

Does your child wear glasses or contacts? ☐ Yes or ☐ No
☐ Glasses ☐ Contacts ☐ Both

Is there any other medical information we need to know? _____

_____

_____

_____

DEVELOPMENTAL HISTORY

Please indicate the age or range when your child performed the following milestones.
(Check 1 box per row):

MILESTONE	0-3 MONTHS	4-6 MONTHS	7-12 MONTHS	13-18 MONTHS	19-24 MONTHS	2-3 YEARS	3-4 YEARS	OTHER (SPECIFY AGE)
Sat up without help								
Rolled over								
Crawled								
Walked alone								
Walked up stairs								

Spoke first words								
Spoke short phrases								
Spoke in sentences								
Fully bladder trained								
Fully bowel trained								
Stayed dry all night								
Drank from cup								
Dressed self								

DIFFERENTIAL BEHAVIORS

Please check below all behaviors or characteristics that fit your child over the past year:

- ☐ Fidgets, is easily distracted, has a hard time staying seated, has difficulty waiting for his/her turn
- ☐ Talks excessively, interrupts often, doesn't listen
- ☐ Low energy/fatigue
- ☐ Poor concentration
- ☐ Difficulty initiating tasks
- ☐ Difficulty completing tasks
- ☐ Difficulty following instructions
- ☐ Engages in impulsive behaviors (acts before thinking)
- ☐ Immature compared to peers
- ☐ Engages in physically dangerous activities
- ☐ Often depressed/irritable mood
- ☐ Often loses things, very disorganized compared to others his/her age
- ☐ Shy
- ☐ Feeling of worthlessness or low self-esteem
- ☐ Withdrawn
- ☐ Overly anxious or fearful
- ☐ Sleeping too little/insomnia
- ☐ Sleeping too much
- ☐ Difficulty making decisions
- ☐ Cries easily
- ☐ Temper Tantrums

- ☐ Often argumentative with adults
- ☐ Often actively defiant to adult requests and rules
- ☐ Blames others for own mistakes
- ☐ Often angry or resentful
- ☐ Somatic complaints of not feeling well
- ☐ Excessive separation difficulties
- ☐ Easily frustrated
- ☐ Lies
- ☐ Steals
- ☐ Aggressive towards others
  - ☐ Adults
  - ☐ Peers
- ☐ Rapid mood changes/mood swings
- ☐ Suicidal thoughts
- ☐ Excessive need for reassurance
- ☐ Poor appetite
- ☐ Overeats
- ☐ Explosive temper with minimal provocation
- ☐ Odd fascinations
- ☐ Unrealistic worry about futures events
- ☐ Substance abuse
  - ☐ Drug
  - ☐ Alcohol
  - ☐ Other

Please explain all checked items: _____

_____

HOME BEHAVIOR:

How often is each of the following settings a problem for your child?

	Rarely	Sometimes	Frequently
While getting ready for school	☐	☐	☐
When eating at the dinner table	☐	☐	☐
When playing by him/herself	☐	☐	☐
When playing with siblings/other children	☐	☐	☐
When with a babysitter or daycare	☐	☐	☐
In public places (church, store)	☐	☐	☐
When in the car	☐	☐	☐

When told to do something he/she doesn't want to do	☐	☐	☐
During sit-down homework time	☐	☐	☐
When watching TV or playing video games	☐	☐	☐

Sensory Processing

Does your child struggle with sensory processing in the following areas?

- ☐ Tactile avoidance or seeking
  (Ex. Avoids: Distress with grooming routines, dislike tags, deams in socks, or being messy / Seeks: touch everything, enjoy being messy)
- ☐ Auditory sensitivity
  (Ex. Cover ears with noises, become upset or startle easily to loud noises, tune out noise or not seem to notice when people are talking to them)
- ☐ Clumsy or uncoordinated
  (Ex. Trip or fall, have difficulty navigating curbs or stairs, be late with motor development, struggle with sports or ball skills)
- ☐ Avoids typical play of kids his/her age
  (Ex. Prefer to play alone, often avoids play with others, has difficulty tolerating change in their play routines)
- ☐ Emotionally reactive
  (Ex. Easily becomes upset, gets frustrated easily, has frequent meltdowns or tantrums, difficult to console)
- ☐ Difficulty with transitions
  (Ex. Melts down when asked to transition or stop activity, needs lots of assistance to stop activity, needs lots of assistance to stop activity and move on to the next task)
- ☐ Does your child struggle with fine motor skills?
  (Ex. Avoid play with small objects, have poor grasp on writing tools, avoid coloring)
- ☐ Does your child struggle with self-care?
  (Ex. Difficulty with dressing, managing zippers/buttons/snaps, unable to tie shoes, poor grasp or use of fork/spoon, difficulty with bathing/grooming, decreased awareness of needing to use the bathroom, inability to wipe self)

Does your child struggle with any of the following:

- ☐ Walking / Running:
- ☐ Coordination / Balance
- ☐ Strength / Flexibility
- ☐ Sports / Other Injury

Please explain _____

_____

Does your child currently do any of the following: (Please check all that apply)

- ☐ Repeat sounds, words, or phrases over and over
- ☐ Understand what you are saying
- ☐ Retrieve/point to common objects upon request (ball, cup, shoe)
- ☐ Follow simple directions (“Shut the door” or “Get your shoes”)
- ☐ Respond correctly to yes/no questions
- ☐ Respond correctly to who/what/where/when/why questions
- ☐ Ask questions of others?
- ☐ Communicate his or her basic wants, needs, and feelings?
- ☐ Comment on daily activities, objects, and people within his or her environment?
- ☐ Participate in conversations with others?

Your child currently communicates using: (Please check all that apply):

- ☐ Body Language
- ☐ 2 to 4 word sentences
- ☐ Words (shoe, doggy, up)
- ☐ Sentences longer than 4 words
- ☐ Sounds (vowels, grunting)
- ☐ Other _____

Please describe your child’s strengths _____

_____

_____

_____

_____

_____

How much of your child's speech do you understand? _____

_____

How much of your child's speech do others understand? _____

_____

Does your child:

- ☐ Engage in turn taking
- ☐ Initiate conversation
- ☐ Greet people arriving or leaving
- ☐ Maintain a topic

Does your child currently…

- ☐ Use a pacifier?
- ☐ Hold food in his/her mouth?
- ☐ Put toys, objects or clothing in his/her mouth?
- ☐ Brush his/her teeth and/or allow brushing?
- ☐ Have difficulty with use of a straw or bottle?
- ☐ Sleep with mouth open, or is his/her mouth open at rest?
- ☐ Choke on food or liquids?
- ☐ Snore?
- ☐ Drool?
- ☐ Eat in a messy manner?
- ☐ Suck his/her thumb?

Is he/she a picky eater? ☐ Yes or ☐ No

If yes, please explain: _____

_____

_____

What do you want us to know about your child that you are not comfortable talking about in front of your child during the evaluation? _____

_____

_____

_____